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ABSTRACT

This special edition contains the background material prepared for the Indian Health Service (IHS) Mental Health Program Review session of January 17-19, 1984 which reviewed the background of the Mental Health Program, assessed the major current management and programmatic issues, and developed recommendations for improving the program. The Review session's agenda is provided and is followed by a listing of the participants. The seven sections of this edition cover the session's discussion topics on the mental health status of American Indians and Alaska Natives, history and description of the program, services for children and adolescents, evaluation and research findings along with needs for an evaluation and reporting system, organization and funding, contracting under P.L. 93-638 (Indian Self-Determination and Education Assistance Act), and exploring and clarifying the mission and future direction of the IHS Mental Health Program. Meant to serve as a basis for discussion during the review, each section provides background information, a bibliography, and illustrative tables regarding its topic. (PM)

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IHS MENTAL HEALTH PROGRAM REVIEW PLENARY SESSION

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RC015338

Introduction

This Special Edition of the Listening Post contains the background material prepared for the Mental Health Program Review of January 17-19, 1984, in Portland, Oregon. The purposes of the Program Review were to review the background of the Mental Health Program, assess the major current management and programmatic issues, and develop recommendations for improving the program. Specific materials were developed as a digest of agenda topics to be covered during the Program Review.

In all, seven chapters covered the discussion topics. These chapters were meant to serve as a basis for discussion during the Review sessions. The final recommendations of the Program Review will become available in late February.

The chapters covering the discussions were drafted by several of the Area Mental Health Branch Chiefs and staff of the Office of Mental Health Programs in Albuquerque, in conjunction with the Office of Planning, Evaluation and Legislation in the Office of the Administrator, HRSA. It is the editors' opinion that the material in these chapters is of sufficient interest to warrant this special edition.

H. C. Townsley, M.D., Director
Office of Mental Health Programs
Indian Health Service

IHS MENTAL HEALTH PROGRAM REVIEW PLENARY SESSION AGENDA

January 17, 1984

8:30	Welcome to the Area	Stanley Stitt
8:35	Comments about the Purpose of the Program Review	Robert Graham
8:50	Comments about the Indian Health Service and Introduction of the Chairperson	Everett Rhoades
9:20	Welcome and Introduction	Chairperson, Irving Berlin
9:30	Discussion I. Mental Health Status of American Indians and Alaska Natives	H.C. Townsley, Moderator Joseph Ball Carl Hammerschlag James Shore

A. Overall population size and characteristics

B. National data concerning the epidemiology of mental health problems, including trends; comparison with the general population

C. Data about particular Areas or localities

D. Cultural dimensions to be considered in planning and delivering mental health services for Indian populations

10:30	Coffee Break	
10:45	Discussion II. History and Description of the Program	Billee VonFumetti, Moderator Robert Bergman John Bjork Lindsley Williams

A. Legislative history

B. History of earmarked funding, by area and nationally, including amounts for direct vs. contracted services.

C. History of relationships with NIMH

D. Summary of the Headquarters, Area and Service Unit organizations

E. National summary of types of services funded, program models, workload and patient statistics

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11:45	Lunch	
1:00	Discussion III. Services for Children and Adolescents	Johanna Clevenger, Moderator Raymond Butler David Heppel Roland Jonnson John Thomas
	A. Early research and Congressional testimony; nature of the problem	
	B. IHS efforts to address the problem	
	1. Ongoing services	
	2. Special projects	
	C. Joint IHS/BIA Indian Children's Program	
2:30	Coffee Break	
2:45	Discussion IV. Evaluation and Research Findings; Needs for Evaluation and Reporting Systems	Robert Walkington, Moderator Morton Beiser Joseph Bloom William Douglas Spero Manson William Richards
	A. Findings, from all sources, relating to the program	
	B. Ongoing studies	
	C. Measures of program success	
	D. Gaps in data, definition of needs by program area and organizational level, and priorities among data needs	
	E. Current systems for program monitoring and needs for changes	
	F. Data sources, processing capacity, and needs for changes	
4:30	Adjournment	
5:30	Social Gathering	
8:30 PM	Optional Event	
	Film: Navajo: Fight for Survival	

January 18, 1984

8:30	Review of previous day's discussion	Irving Berlin
8:45	Discussion V. Organization and Funding	Jack Ellis, Moderator
	A. Role of the Office of Mental Health Programs in relation to the Area Offices and Headquarters East	Michael Biernoff George Blue Spruce James Felsen Edward Kruger Gordon Neligh Margene Tower
	B. Current roles of the mental health staffs in relation to other components at the Areas and Service Units	
	C. Organizational relationships at the Area office and Service Units among mental health, alcoholism, and social services staffs	
	D. Current arrangements for budgeting, allocating and accounting for funds and positions associated with earmarked mental health funds, and related issues	
	1. Approaches for projecting needs for funds and staff to deliver or contract for services	
	2. Approaches for projecting needs for travel and training, and their relationship to the programmatic mission	
	E. Implications for the Mental Health Program of the effort to increase substantially third-party reimbursement; sources of reimbursement	
	F. Organizational implications of the jurisdicational, legal, health and financial issues relating to involuntary commitment	
	G. Impact of organization on the quality of clinical services	
9:45	Coffee Break	
10:00	Discussion V. Continuation	

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10:45	Discussion VI. Contracting Under P.L. 93-638	Ronald Carlson Moderator Roland Johnson William Richards Stanley Stitt Richard Winslow
	A. Trends in levels of 638 contracting, exemplary contracts involving mental health services	
	B. Lessons learned from experiences with 638 contracting	
	C. Standards for hiring under 638 contracts; ways to help tribes maintain standards	
	D. Roles of mental health staff in establishing and evaluating mental health services under tribal contracts	
12:00	Lunch	
1:30	Discussion VI. Continuation	
2:30	Coffee Break	
2:45	Discussion VII. Rethinking the Mission and Future Direction of the IHS Mental Health Program	William Hunter, Moderator Gordon Neligh Luana Reyes John Thomas Billee VonFumetti Marian Zonnis
	A. Underlying concepts: for example, how "need" and "unmet need" should be defined; needs on reservations vs. in urban areas	
	B. Categories of services to consider in defining need	
	1. Prevention	
	2. Outpatient	
	3. Inpatient	
	4. Community consultation and education	
	C. Alternative programmatic emphases; prevention vs. cure; medical vs. public health model	
4:30	Adjournment	

January 19, 1984

8:30	Review of previous day's discussion	Irving Berlin
8:45	Discussion VII. Continuation	
	D. Relative priority among the various categories	
	E. Implications of the projected mission for particular types of facilities and services, including:	
	1. Care for the chronically mentally ill	
	2. Model dormitories	
	3. Special problems, such as prevention and treatment of drug abuse	
	4. Needs for services for children and adolescents	
	F. Implications of organization for the programmatic mission	
10:00	Coffee Break	
10:15	Discussion VII. Continuation	
11:30	Lunch	
1:00	Discussion VIII. Recommendations from the Plenary Session	Irving Berlin
	A. Summary of highlights from all earlier Discussions	
	B. Development of recommendations by the group as a whole	
3:15	Closing Comments	Everett Rhoades

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IHS Mental Health Plenary Session Participants

Indian Health Service

Michael P. Biernoff, M.D.	Mental Health Branch Chief, Albuquerque Area
John W. Bjork, A.C.S.W.	Mental Health Branch Chief, Oklahoma Area
George Blue Spruce, Jr., D.D.S.	Area Director, Phoenix Area
William Douglas, Ph.D.	Office of Mental Health Programs, Headquarters West
Jack Ellis, M.D.	Former Deputy Director and Chief Medical Officer, Albuquerque Area; currently on detail to the Office of Mental Health Programs
James D. Felsen, M.D.	Acting Director, Division of Program Operations and Chief Medical Officer, IHS
Carl Hammerschlag, M.D.	Chief of Psychiatry, Phoenix Indian Medical Center
Albert B. Hiat, Ph.D.	Acting Director, IHS/BIA Indian Children's Program
William B. Hunter, III, M.D.	Deputy Director, Office of Mental Health Programs
Edward Kruger	Service Unit Director, Ada, Oklahoma
Peter M. Nakamura, M.D.	Deputy Area Director and Chief Medical Officer, Portland Area
Gordon Neligh, M.D.	Area Psychiatrist, Billings Area
Luana Reyes	Director, Division of Program Formulation, IHS. Former Director, Payallup Health Authority and Director, Seattle Health Board
William Richards, M.D.	Mental Health Branch Chief, Alaska Area
Everett R. Rhoades, M.D.	Director, Indian Health Service
C. Stanley Stitt, Jr., D.D.S.	Area Director, Portland Area

John Thomas, M.D.	Chief, Mental Health Service, Gallup Indian Medical Center, Gallup
Margene Tower, R.N., M.S.	Mental Health Branch Chief, Billings Area
H.C. Townsley, M.D., M.P.H.	Director, Office of Mental Health Programs
Billee VonFumetti, R.N., M.S., M.P.H.	Mental Health Branch Chief, Portland Area
Richard Winslow, M.D.	Chief, Department of Psychiatry, Alaska Native Medical Center, Anchorage
Marian E. Zonnis, M.D.	Mental Health Branch Chief, Navajo Area

Bureau of Indian Affairs

Raymond B. Butler, M.S.W.	Chief, Division of Social Services, Bureau of Indian Affairs
Roland Johnson	Superintendent, Laguna Agency, Laguna, New Mexico. Former Director, IHS/BIA Indian Children's Program

Indian Practitioners

Joseph W. Ball, M.D.	Psychiatrist in private practice in Portland, Oregon. Psychiatric consultant to the Portland Urban Indian Health Program
Johanna Ghe-e-bah Clevenger, M.D.	Adult and child psychiatrist in private practice in Dallas. President, Association of American Indian Physicians
R. Dale Walker, M.D.	Chief, Alcohol Dependence Treatment Program, Seattle Veterans Administration Medical Center. Also Associate Professor, Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Washington. Research on Indian alcoholism and mental health issues. Chairman, American Psychiatric Association Committee on Indian and Alaska Native Affairs

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Researchers in Indian Mental Health

Morton Beiser, M.D.	Professor and Head, Division of Social and Cultural Psychiatry, University of British Columbia, Vancouver. Canada Health and Welfare National Health Research Scholar. Principal investigator on 1973-1976 studies on the IHS Mental Health Program
Robert L. Bergman, M.D.	Clinical Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Washington. Director of the IHS Mental Health Program 1969-1975
Irving Berlin, M.D.	Chief, Division of Child Psychiatry, Department of Psychiatry, University of New Mexico, School of Medicine. Has published widely in the field of child psychiatry
Joseph D. Bloom, M.D.	Vice Chairman, Department of Psychiatry, Oregon Health Sciences University. Research on multiple mental health issues, including studies of Alaska Natives. Former IHS Area Psychiatrist
Spero M. Manson, Ph.D.	Associate Professor and Director, Social Psychiatric Research, the Oregon Health Sciences University. Former Research Director, National Center for American Indian Mental Health Research, Oregon Health Sciences University
James H. Shore, M.D.	Professor and Chairman, Department of Psychiatry, Oregon Health Sciences University. Also Assistant Dean for Curriculum, School of Medicine, OHSU. Has published a number of articles about Indian Mental Health. Former Mental Health Branch Chief

Other Federal Representatives

Ronald H. Carlson	Chairman, Steering Committee for the Program Review. Associate Administrator for Planning, Evaluation and Legislation, HRSA

Robert Graham, M.D.	Administrator, HRSA
David Heppel, M.D.	Former Director of the IHS/BIA Indian Children's Program. Now Chief for Child and Adolescent Primary Care Services, Division of Maternal and Child Health, Bureau of Health Care Delivery and Assistance, HRSA
Robert A. Walkington	Director, Office of Program Development, Bureau of Health Professions, HRSA. Has extensive experience in evaluation of federal health programs and in program reviews
Lindsley Williams	Director, Office of Policy Development, Planning and Evaluation, NIMH. Was major liaison between IHS and NIMH for several years

National Indian Health Board

Jake Whitecrow	Executive Director, National Indian Health Board

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Mental Health Status of American Indians and Alaska Natives

Background for Discussion I

The Indian Health Service began its Mental Health Program in 1966. The service population was composed of 500,000 American Indians and Alaska Natives.* This initially modest program recognized that the effects of poverty, forced abandonment of traditional ways of life, inadequate schools, disruptive stresses on the Indian family, as well as a harsh physical environment were but some of the elements of a situation which frustrated many American Indian people in their attempt to live self-respecting and productive lives. The results of these conditions were associated with a high incidence of violence, accidents, suicide, homicide, neglect of children, and community and family disorganization. These devastating incidents had a high correlation with the concomitant use or abuse of alcohol.

As of 1980, there were 1.4 million American Indians; of these, about 800,000 were in recognized tribes and eligible for services from IHS (Tables 1, 2, and 3). The traditional locations and cultural groupings are described briefly in an excerpt from the 1957 HEW report, Health Services for American Indians (1).

It is relatively easy to speak of Indians and Alaska Natives and make generalizations about them. The pitfall in this is the danger of thinking as if they are a homogeneous group. This is most definitely not the case. One tribe will be distinctly different from another in causes of mortality. Shore and Manson note their concern about stereotyping Indians in their 1983 "Overview of American Indian Psychiatric and Social Problems" (2). Furthermore, the American Indian population is divided between those Indians living on reservations and those living off the reservations, that is, in rural or urban areas.

The ten leading causes of death for the Indian population, according to the most recent three year mortality rate, 1978-80, are:

1. Diseases of the heart
2. Accidents
3. Malignant neoplasms
4. Chronic liver disease and cirrhosis
5. Cerebral vascular diseases
6. Pneumonia and influenza
7. Homicide
8. Diabetes mellitus
9. Certain conditions originating in the perinatal period
10. Suicide

As shown in Figure 1, the death rates from suicide, homicide, accidents, and liver disease are markedly higher than those of the U.S. population as a whole. Further comparison shows that high death rates, from conditions associated with stress and violent behavior, at

*Unless otherwise specified, the term "American Indians" is intended to encompass Alaska Natives throughout this document.

Table 1

INDIAN AND ALASKAN NATIVE POPULATION - 1980

1980 CENSUS DATA	Total Population	Non-Res. States	Reservation States	Service	Non-Service
TOTALS	1,418,195	177,811	1,240,384	828,609	411,775
Alabama	7,561	7,561			
Alaska	64,047		64,047	64,047	
Arizona	152,857		152,857	152,857	
Arkansas	9,411	9,411			
California	201,311		201,311	67,251	134,060
Colorado	18,059		18,059	2,806	15,253
Connecticut	4,533	4,533			
Delaware	1,330	1,330			
District of Columbia	1,031	1,031			
Florida	19,316		19,316	3,868	15,448
Georgia	7,619	7,619			
Hawaii	2,778	2,778			
Idaho	10,521		10,521	7,048	3,473
Illinois	16,271	16,271			
Indiana	7,835	7,835			
Iowa	5,453		5,453	1,845	3,608
Kansas	15,371		15,371	3,019	12,352
Kentucky	3,610	3,610			
Louisiana	12,064		12,064	622	11,442
Maine	4,087		4,087	2,698	1,389
Maryland	8,021	8,021			
Massachusetts	7,743	7,743			
Michigan	40,038		40,038	8,369	31,669
Minnesota	35,026		35,026	16,866	18,160
Mississippi	6,180		6,180	4,155	2,025
Missouri	12,319	12,319			
Montana	37,270	—	37,270	30,893	6,377
Nebraska	9,197		9,197	3,892	5,305
Nevada	13,304		13,304	13,304	
New Hampshire	1,352	1,352			
New Jersey	8,394	8,394			
New Mexico	104,777		104,777	102,374	2,403
New York	38,732		38,732	9,718	29,014
North Carolina	64,635		64,635	5,604	59,031
North Dakota	20,157		20,157	16,329	3,828
Ohio	12,240	12,240			
Oklahoma	169,464		169,464	169,464	
Oregon	27,309		27,309	13,124	14,185
Pennsylvania	9,459		9,459	66	9,393
Rhode Island	2,898	2,898			
South Carolina	5,758	5,758			
South Dakota	45,101		45,101	41,340	3,761
Tennessee	5,103	5,103			
Texas	40,074	40,074			
Utah	19,256		19,256	8,781	10,475
Vermont	984	984			
Virginia	9,336	9,336			
Washington	60,771		60,771	56,003	4,768
West Virginia	1,610	1,610			
Wisconsin	29,497		29,497	17,451	12,046
Wyoming	7,125		7,125	4,815	2,310

OPS/DRC/IHS August 24, 1981

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Table 2

NUMBER AND PERCENT DISTRIBUTION OF THE TOTAL AMERICAN INDIAN AND ALASKA NATIVE POPULATION FOR RESERVATION STATES AND U.S. ALL RACES BY AGE, 1980 CENSUS DATA

	American Indian & Alaska Native		U.S. All Races	
	Number	Percent 1/	Number	Percent 1/
Total	1,240,384	100.000	226,504,825	100.000
Under 5 years	135,239	10.903	16,344,407	7.216
5 to 9 years	131,735	10.621	16,697,134	7.372
10 to 14 years	140,028	11.289	18,240,919	8.053
15 to 19 years	150,897	12.165	21,161,667	9.343
20 to 24 years	128,304	10.344	21,312,557	9.409
25 to 29 years	107,131	8.637	19,517,672	8.617
30 to 34 yeas	91,175	7.351	17,557,957	7.752
35 to 39 years	71,100	5.732	13,963,008	6.165
40 to 44 years	58,755	4.737	11,668,239	5.151
45 to 49 years	49,460	3.988	11,088,383	4.895
50 to 54 years	43,954	3.544	11,708,984	5.169
55 to 59 years	38,270	3.085	11,614,054	5.128
60 to 64 years	29,234	2.357	10,085,711	4.453
65 to 69 years	24,737	1.994	8,780,844	3.877
70 to 74 years	17,243	1.390	6,796,742	3.001
75 to 79 years	11,871	0.957	4,792,597	2.116
80 to 84 years	6,105	0.492	2,934,229	1.295
85 years & over	5,146	0.415	2,239,721	0.989

1/ Percentages may not add to the totals due to rounding.

Population Branch
OPS/DRC/IHS
March 3, 1983

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Table 3

ESTIMATED INDIAN & ALASKA NATIVE SERVICE POPULATION BY AREA

AREA	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
ALL AREAS	828,609	847,282	866,040	885,345	905,209	925,641	946,619	968,161	990,263	1,012,912	1,036,127
ABERDEEN AREA	63,253	64,833	66,444	68,088	69,770	71,492	73,244	75,036	76,859	78,721	80,615
ALASKA AREA	64,047	65,561	67,109	68,692	70,307	71,960	73,642	75,360	77,110	78,892	80,702
ALBUQUERQUE AREA	46,610	47,634	48,681	49,753	50,848	51,972	53,123	54,291	55,489	56,709	57,956
BEMIDJI PROGRAM AREA	42,686	43,626	44,628	45,682	46,789	47,959	49,170	50,451	51,783	53,169	54,617
BILLINGS AREA	35,708	36,719	37,773	38,859	39,993	41,161	42,369	43,619	44,905	46,230	47,593
CALIFORNIA PROGRAM AREA	65,757	66,873	68,066	69,333	70,673	72,088	73,578	75,144	76,782	78,494	80,278
NAVAJO AREA	145,162	149,011	152,923	156,902	160,943	165,044	169,213	173,435	177,726	182,080	186,496
OKLAHOMA CITY AREA	172,636	175,984	179,454	183,043	186,748	190,565	194,503	198,550	202,715	207,001	211,408
PHOENIX AREA	74,020	76,057	77,651	79,286	80,956	82,683	84,453	86,267	88,135	90,043	92,004
PORTLAND AREA	75,769	77,334	78,950	80,615	82,335	84,097	85,913	87,779	89,689	91,652	93,657
TUCSON PROGRAM AREA	16,230	16,531	16,846	17,177	17,524	17,884	18,260	18,651	19,056	19,476	19,912
U.S.E.T. PROGRAM AREA	26,731	27,119	27,515	27,915	28,323	28,736	29,151	29,578	30,014	30,445	30,889

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Selected Age-Adjusted Death Rates

Ratio of Indians & Alaska Natives to U.S. All Races (CY '79)

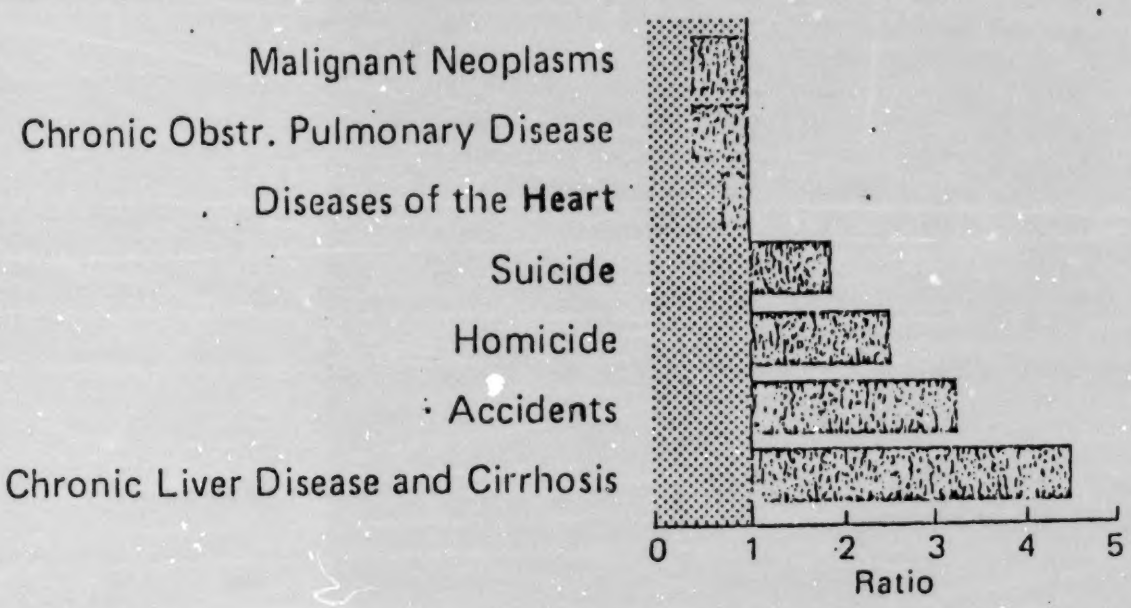

FIGURE 1

least in the area of suicide, have existed for the past decade (Table 4).

The age pattern of suicides is different from that of the nation as a whole. The period of greatest vulnerability for Indians is the 15 to 24 year age range; the suicide rate for the U.S. as a whole tends to rise with age (Table 5).

Rates for other markers of stress and/or violent behavior--accidents, alcohol-related deaths and homicides--all are significantly higher than the national averages (Tables 4, 5, and 6 and Figure 2). Because stress-related problems occur most frequently among teenagers and young adult Indians and because the majority of the Indian population is young, the risk of death related to stress and violent behavior is likely to remain high for the foreseeable future.

Table 7 depicts mental health and alcoholism discharges and patient contacts from IHS and contract facilities for the period 1977-1980. Table 8 compares discharges and discharge rates for all mental disorders in IHS and U.S. short-stay hospitals. Data for 1977 from the Alaska Native Health Service show that about 8 percent of the population were seen for mental disorders.

Classes of Psychiatric Problems and their Epidemiology

As is true for other populations, mental health problems for American Indians cut across all diagnostic categories. The following listing, not intended to be inclusive, highlights a number of the psychiatric problems encountered by IHS personnel. These diagnostic categories all relate to the general problems noted in the preceding pages.

Depression: According to our data, depression is a major problem among American Indians. (See White Cloud Journal, Volume 2, Number 2, 1981.) Depression often presents with physical complaints, and we believe that many of the patients who present in our outpatient medical clinics belong to this category. Death on the reservation due to suicide, motor vehicle accidents, homicide, and alcoholism is highly correlated with depression. These deaths in turn increase the likelihood of depression in surviving family members, friends, and the community as a whole.

The study of depression in American Indian populations currently underway at the Oregon Health Sciences University may give us a better understanding of the psychodynamics and epidemiology of depression in American Indian communities. We need to correlate that information with effective treatment, which can best be done through adequate training and by making the newer drugs available for use when appropriate, in conjunction with psychotherapy and other treatment modalities.

Emotional Problems of Children: According to studies conducted by the White Cloud Center, we estimate that there are

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Table 4

Suicide Deaths and Rates per 100,000 Population for Indians and Alaska Natives in Reservation States and the United States, All Races and Other than White, 1959-1980

Between 1959 and 1970 the age adjusted suicide death rates for Indians and Alaska Natives has been about 1 1/2 times the national rate. Starting in 1971 the Indian rate has gradually increased, and by 1977 it was more than double the national level. In 1980 however the age-adjusted rate declined to 14.1, due in part to the increase in population counted during the 1980 Census. In 1980 there were 173 Indian and Alaska Native suicide deaths as compared with counts of 150 and 188 for 1978 and 1979 respectively.

	Number		Crude Rates		Age Adjusted Rates and Their Ratio				
						United States:		Ratio of Indians to :	
Calendar Year 1/	Indians and Alaska Natives	U.S All Races	Indians and Alaska Natives	U.S. All Races	Indians and Alaska Natives	All Races	Other than White	U.S. All Races	U.S. Other than White
1980	173				14.1	11.4	6.7	1.2	2.1
1979	188	26,869	16.1	12.4	21.8	11.9	7.9	1.8	2.8
1978	150	27,294	19.0	12.5	18.5	12.0	7.4	1.5	2.5
1977	199	28,681	19.2	13.3	26.6	12.9	7.8	2.1	3.4
1976	168	26,832	21.0	12.5	22.5	12.3	7.6	1.8	3.0
1975	180	27,063	19.9	12.7	26.0	12.6	7.5	2.1	3.5
1974	148	25,683	19.9	12.1	21.8	12.2	7.2	1.8	3.0
1973	149	25,118	18.8	12.0	22.9	12.0	7.2	1.9	3.2
1972	138	25,004	18.8	12.0	20.6	12.1	7.5	1.7	2.7
1971	135	24,092	17.4	11.7	21.8	11.9	7.0	1.8	3.1
1970	105	22,630	15.9	11.6	17.9	11.8	6.5	1.5	2.8
1969	94	22,364	14.1	11.1	16.8	11.3	6.3	1.5	2.7
1968	90	21,372	14.0	10.7	17.5	11.0	5.7	1.6	3.1
1967	94	21,325	12.9	10.8	16.2	11.1	6.1	1.5	2.7
1966	64	21,281	12.0	10.9	15.2	11.2	6.1	1.4	2.5
1965	65	21,507	10.1	11.1	12.9	11.4	6.1	1.1	2.1
1964	52	20,588	11.6	10.8	15.8	11.0	5.6	1.4	2.8
1963	66	20,825	11.4	11.0	15.6	11.3	6.0	1.4	2.6
1962	59	20,207	12.1	10.9	16.9	11.1	5.6	1.5	3.0
1961	61	18,999	11.7	10.4	16.7	10.5	5.6	1.6	3.0
1960	57	19,041	11.7	10.6	16.8	10.6	5.4	1.6	3.1
1959	57	18,633	11.7	10.6	17.0	10.6	5.5	1.6	3.1

1/ Indian and Alaska Native crude rates are 3-year rates centered in the year specified. All other rates are based on single year data. Estimated population methodology for the Indian population revised in 1976. Decennial Census population counts used for 1960, 1970 and 1980. "Suicide is suspected of being grossly understated in the statistics based on cause-of-death certification. A general reluctance to admit suicidal intent of friends and relatives and difficulties in recognizing it under certain circumstances undoubtedly result in underreporting. Various estimates have been made of the actual occurrence of suicide, some indicating that it is as much as twice the reported figure." Source: Suicide in the United States 1950-1964, National Center for Health Statistics Series 20, Number 5.

Prepared by: Vital Events Branch OPS/DRC/IHS November 14, 1983

Table 5

AGE SPECIFIC MORTALITY RATES PER 100,000 POPULATION
FOR INDIANS AND ALASKA NATIVES IN RESERVATION STATES, U.S. ALL RACES
AND U.S. OTHER THAN WHITE

The Indian and Alaska Native 3-year average age specific suicide rate for the 15-24 year old category has remained almost stable over the past 3 years (more than 3 times the national rate). Suicide mortality rates for 10-year age groups beginning at age 45 for the Indian population are lower than those of the U.S. population between 3 and 15 deaths per 100,000 population. Suicide rates for the U.S. Other than White population (1978) for the age groups shown below are lower than those for Indians and Alaska Natives (1977-79) except for age groups 65-74 and 75-84.

	IHS			U.S. All Races 1978	U.S. Other than White 1978	Ratio IHS 77-79 to: U.S. All Races(78)	Ratio IHS 77-79 to: U.S. Other than White (78)
	1977-79 1/	1976-78 1/	1975-77 1/				
				SUICIDE			
Under 1	-	-	-	-	-	-	-
1 - 4	-	-	-	-	-	-	-
5 - 14	1.0	1.4	1.0	0.4	0.3	2.5	3.3
15 - 24	44.7	44.3	46.1	12.4	8.9	3.6	5.0
25 - 34	41.8	42.2	46.3	16.7	13.9	2.5	3.0
35 - 44	28.9	31.1	38.6	15.8	10.3	1.8	2.8
45 - 54	14.5	13.2	17.3	17.1	8.6	0.8	1.7
55 - 64	11.6	11.4	13.2	18.1	6.9	0.6	1.7
65 - 74	5.1	5.4	3.3	18.8	6.7	0.3	0.8
75 - 84	7.5	5.2	5.4	22.6	8.0	0.3	0.9
85+	7.6	8.0	5.4	18.6	6.3	0.4	1.2

1/ Estimated population methodology revised in 1976. Maine, New York and Pennsylvania included as reservation states beginning in 1979.

Source: Indians and Alaska Natives--Indian Health Service, IHS
U.S. All Races and U.S. Other than White, 1978--National Center for Health Statistics, PHS - unpublished.

Vital Events Branch
OPS/DRC/IHS
March 18, 1982

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Table 6

AGE SPECIFIC MORTALITY RATES PER 100,000 POPULATION
FOR INDIANS AND ALASKA NATIVES IN RESERVATION STATES, U.S. ALL RACES
AND U.S. OTHER THAN WHITE

The 3-year average age specific homicide rate for Indians and Alaska Natives 25-34 and 45-54 were 58 and 31 deaths per 100,000 population respectively (1977-1979). These rates are 3.4 and 3.2 times the national rates for 1978. Except for age 85+ years, age specific homicide rates for the U.S. Other than White population exceed those for the Indian and Alaska Native population for each of the age groups shown below.

Indians and Alaska Natives in the age groups 25-34, 35-44, and 45-54 years of age experienced alcoholism mortality rates 1977-1979 which were 25, 11, and 7 times the national levels. Indian and Alaska Native alcoholism mortality rates for 10-year age groups between ages 25-84 years are 2.1 to 6.7 times as high as comparable rates for the U.S. Other then White population.

	I H S			U.S. All Races	U.S. Other than	Ratio IHS 77-79 to:	
	1977-79 1/	1976-78 1/	1975-77 1/	1978	White 1978	U.S. All Races(78)	U.S. Other than White (7
				ALCOHOLISM 2/			
Under 1	-	-	-	-	-	-	-
1 - 4	-	-	-	0.0	-	-	-
5 - 14	0.1	0.1	0.1	0.0	0.0	-	-
15 - 24	7.9	9.8	11.1	0.4	0.9	19.8	8.8
25 - 34	71.2	72.4	76.3	2.9	10.7	24.6	6.7
35 - 44	129.9	150.0	152.9	11.6	35.7	11.2	3.6
45 - 54	158.7	165.8	166.6	22.8	47.5	7.0	3.3
55 - 64	137.3	136.4	123.9	26.8	47.9	5.1	2.9
65 - 74	56.2	58.9	57.6	20.1	26.2	2.8	2.1
75 - 84	29.9	34.0	35.2	8.8	14.1	3.4	2.1
85+	7.6	8.0	24.8	3.2	4.9	2.4	1.6
				HOMICIDE			
Under 1	8.4	8.8	10.6	5.0	12.0	1.7	0.7
1 - 4	6.3	6.2	7.2	2.6	7.1	2.4	0.9
5 - 14	1.5	2.2	1.7	1.3	2.9	1.2	0.5
15 - 24	34.9	33.6	30.9	13.2	40.6	2.6	0.9
25 - 34	58.2	54.9	52.5	16.9	64.7	3.4	0.9
35 - 44	29.3	33.4	29.4	14.0	50.6	2.1	0.6
45 - 54	31.4	36.3	34.5	9.9	35.4	3.2	0.9
55 - 64	18.6	18.8	14.6	6.7	25.7	2.8	0.7
65 - 74	10.2	8.6	10.0	5.0	17.8	2.0	0.6
75 - 84	10.0	7.8	13.5	4.7	13.8	2.1	0.7
85+	15.3	16.0	16.6	4.4	8.1	3.5	1.9

0.0 - Rounds to zero.

1/ Estimated population methodology revised in 1976. Maine, New York and Pennsylvania included as reservation states beginning in 1979.

2/ For 1974-1978: Includes alcoholism, alcoholic psychosis, and cirrhosis of the liver with mention of alcohol.
For 1979: Includes alcohol dependence syndrome, alcoholic psychosis and chronic liver disease and cirrhosis with mention of alcohol.

Source: Indians and Alaska Natives--Indian Health Service, IHS
U.S. All Races and U.S. Other than White, 1978--National Center for Health Statistics, PHS - unpublished.

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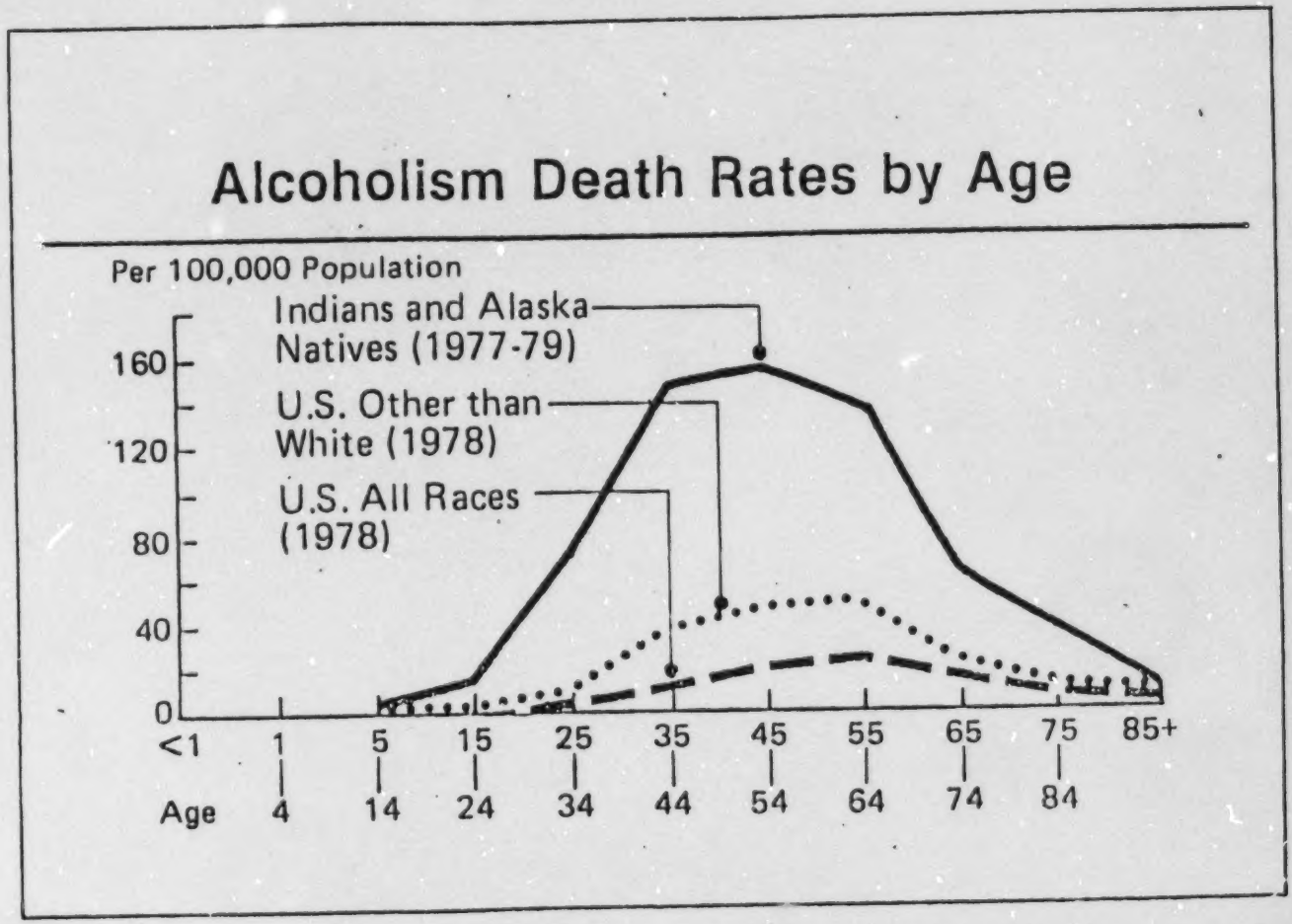

FIGURE 2

Table 7

MENTAL HEALTH AND ALCOHOLISM DISCHARGES AND PATIENT CONTACTS, TOTALS AND PERCENTAGES OF TOTALS FROM FOUR MAJOR IHS RECORDS SYSTEMS FY 1977-1981[1]

			TOTALS					PERCENTAGES				
			1981	1980	1979	1978	1977	1981	1980	1979	1978	1977
In Patient Services	Direct	Total Dischg.	81,645	77,481	73,049	75,271	77,007	100.0	100.0	100.0	100.0	100.0
		All 290-319	4,614	4,561	4,416	4,524	5,063	5.7	5.9	6.0	6.0	6.6
		M. H.	1,424	1,462	1,388	1,367	1,490	1.7	1.9	1.9	1.8	1.9
		ALCOH.	3,190	3,099	3,028	3,157	3,573	3.9	4.0	4.2	4.2	4.6
	Contract	Total Dischg.	26,217	28,943	29,194	32,364	29,384	100.0	100.0	100.0	100.0	100.0
		All 290-319	1,532	1,720	1,525	1,552	1,781	5.8	5.9	5.2	4.8	6.0
		M. H.	623	711	430	491	531	2.4	2.5	1.5	1.5	1.8
		ALCOH.	909	1,009	1,095	1,016	1,250	3.5	3.5	3.8	3.1	4.3
Out Patient Services	APC	Total Prob.	3,319,479	3,194,936	3,083,350	3,124,716	2,960,850	100.0	100.0	100.0	100.0	100.0
		All 120-175	73,971	69,422	67,811	62,194	61,247	2.2	2.2	2.2	2.0	2.1
		M. H.	56,652	51,746	46,176	42,707	41,798	1.7	1.6	1.5	1.4	1.4
		ALCOH.	17,319	17,676	21,635	19,487	19,449	.5	.6	.7	.6	.7
	Contract	Total Prob.	111,018	137,860	159,190	264,020	259,507	100.0	100.0	100.0	100.0	100.0
		All 120-175	2,842	3,247	4,057	3,300	4,369	2.6	2.4	2.5	1.3	1.7
		M. H.	1,982	2,346	2,778	2,386	3,210	1.8	1.7	1.7	.9	1.2
		ALCOH.	860	901	1,279	914	1,159	.8	.7	.8	.4	.4

1) Does not include mental health and social service reporting.

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Table 8

NUMBER OF DISCHARGES AND DISCHARGE RATES 1/ FOR MENTAL DISORDERS INDIANS AND ALASKA NATIVES AND U.S. ALL RACES

	ICD-9-CM Code Nos.	IHS & Contract FY 1982 Number	IHS & Contract FY 1982 Rate	U.S. Short-Stay CY 1980 Number (1,000s)	U.S. Short-Stay CY 1980 Rate	IHS & Contract FY 1971 Number	IHS & Contract FY 1971 Rate	U.S. All Races CY 1971 Number (1,000s)	U.S. All Races CY 1971 Rate
Total	290-319	4,954	63.1	1,692	75.8	5,310	115.4	1,050	51.9
Alcoholism	291,303, 305.0	3,194	40.7	543	24.3	3,386	73.6	210	10.4
Psychoses (non-organic)	295-299	496	6.3	393	17.6	329	7.1	220	10.9
Neuroses & personality disorders	300-302	509	6.5	335	15.0	1,030	22.4	405	20.0
All other		755	9.6	421	18.9	565	12.3	215	10.6

1/ Number of discharges per 10,000 population.

Source: IHS and Contract General Hospitals: Annual Reports 2C and 3I
U.S. Short-stay Hospitals: National Center for Health Statistics, DHHS, unpublished data.

Inpatient Care Branch
OPS/DRC/IHS
January 27, 1983

35,000 to 50,000 children with severe emotional problems in the service population. (See White Cloud Journal, Volume 2, Number 2, 1983.) Diagnostic and treatment skills for dealing with children are highly specialized and require specific training, which most of our staff do not have. (These problems will be considered further in Discussion III, Services for Children and Adolescents.)

Alcohol and Drug Problems: Empirical evidence suggests that the concomitant use or abuse of alcohol and/or drugs has a strong relationship to several psychiatric disorders. Some of these disorders are relatively more amenable to treatment, if begun early, such as depression, and others, such as personality disorders, are not. Anxiety disorders, organic brain syndromes, borderline state, manic depressive illness and several psychotic disorders are also often related to alcohol and drug abuse. It remains to be seen how many of the alcohol and drug abuse problems can be resolved through adequate treatment of the underlying psychiatric pathology.

Training of detox staff in the recognition of psychiatric disorders and of mental health staff in working with alcoholism or drug abuse is another area of need.

Somatoform Disorders and Psychophysiologic Disorders: There is a large body of evidence that a high percentage of the people using ambulatory medical facilities have underlying psychiatric disorders. Further studies suggest that only a small fraction of these people are recognized and that some of those are never adequately treated. In addition, people with psychiatric disorders presenting with physical compliants utilize a disproportionately larger number of expensive diagnostic tests and more man hours, etc., as compared with patients with strictly medical problems. Examples include panic disorder presenting with symptoms much like heart attack, hyperventilation appearing similar to some neurological disorders, and psychophysiologic disorders in which the patient's emotional state modifies the course of physical illness.

Personality Disorders: There is a wide range of personality disorders present in every population. Such patients in IHS produce disproportionate financial and personnel drains on our system. Unfortunately, treatment of these people is neither quick nor easy and requires complex therapeutic skills. Adequate training of treatment and administrative staff in recognition of narcissistic and borderline personalities would, however, lessen the chaos these patients cause and their negative impact on the staff.

Chronically Mentally Ill: These patients, fortunately, represent a small fraction of the total IHS caseload. Unfortunately, though, these patients utilize a disproportionate amount of IHS resources. They represent a number of diag-

nostic groups, including mental retardation, schizophrenia, bipolar affective disorders and others. Probably more litigation has taken place because of and on behalf of this population than all other groups combined. Court decisions seem to require a complex network of treatment and followup services, especially for those involuntarily committed. Very few of the required services exist on the reservation.

The effort to develop tribal commitment procedures consistent with the White v. Califano decision is one area to be more fully pursued. In addition, we need treatment facilities, transitional living facilities, and a network of volunteer case managers for follow up on every reservation. (Civil commitment issues are considered in Discussion V, Organization and Funding.)

Organic Brain Syndromes: There are many identified medical causes of organic brain syndrome that present with psychiatric symptoms. It is essential that these disorders be distinguished from the functional disorders. Many physicians and other health care workers are not adequately trained to provide these diagnostic services. Many of these organic brain syndromes can be effectively treated and even reversed if diagnosed properly and treated adequately. Common organic brain syndromes which may be reversible early in their course are metabolic abnormalities associated with alcoholism. We currently have no quantitative data about undiagnosed and untreated organic brain syndrome in reservation communities, but we suspect there are far more cases of this unrecognized problem than we are aware of at present.

Training is needed for physicians in the medical diagnosis and treatment of these conditions; for alcoholism workers in the recognition of common danger signs, so they can perform a triage function at the detox units and in jails; and for social service staff in treatment, placement and supervision needs of those who are untreatable; for nursing home staff in behavior management; and for mental health staff in emotional problems of people with organic brain syndrome and the functionally mentally retarded.

Problems of Daily Living: These problems encompass a range of crisis situations including marital disputes, suicide attempts and gestures, domestic violence, and sexual abuse. Our staff generally does very well with these problems. Our major lack in this area is in the number of staff, rather than in lack of training or technical skills. Another problem is that the capacity to make outside referrals is severely impaired, secondary to shortages in IHS Contract Health Services funds; consequently, the mental health staff is doing primarily crisis work, with very little long term treatment or prevention capability.

Culture Specific Syndromes: There is evidence that several culture specific psychiatric syndromes exist, such as the

problem known as Windigo Psychosis among the Chippewa. In addition, culture specific presentations of emotional problems of all kinds are just beginning to be understood. We currently have almost no idea of how these culture specific syndromes affect mental health on reservations. Creative outreach and primary prevention programs are needed as well as systematic studies in this area.

Miscellaneous Psychiatric Conditions: Other miscellaneous disorders, which may have a very low incidence, make the presence of a psychiatrist at the Area level highly desirable. Examples are genetic disorders in children, childhood autism, childhood schizophrenia, hyperkinesis, learning disorders, psychosexual disorders, and phobic conditions.

There has been substantial improvement in the health status of Indian people. Markides (3) notes a marked reduction in the death rate of, and increase in life expectancy for, the American Indian population since 1970. He attributes the former to a sharp reduction in infant mortality. He goes on, however, to cite a study of Navajo mortality rates showing death by accidents as the leading cause of mortality among Navajo males. Similar high death rates associated with violence are demonstrated in an epidemiological study of Alaska Natives done by the Centers for Disease Control.

Since the Indian Health Service was established in 1955, there has been a significant shift in the nature of major health problems among American Indians. Currently, a much higher proportion of illness and death stems from behavioral causes and chronic maladaptive life styles, which are less amenable to treatment.

In a 1957 report to Congress on a study carried out in conjunction with the transfer of health care responsibilities to the USPHS, seven health problems were identified as "of greatest urgency among Indians." These were tuberculosis, pneumonia and other respiratory diseases, diarrhea and other enteric diseases, accidents, eye and ear diseases and defects, dental disease, and mental illness. High death rates were associated with the first four and the last.

A review of the changes in leading causes of death for American Indians and Alaska Natives from 1955 to 1976-78 (see Table 9) indicates that five causes have shown a marked increase: cirrhosis of the liver (an increase of 159 percent); suicide (an increase of 102 percent); homicide (an increase of 37 percent); diabetes mellitus (an increase of 27 percent); and malignant neoplasms (an increase of 4 percent). Accidents, which are currently a leading cause of death among Indians and Alaska Natives, shows a 14 percent decrease during this period. All other causes, including tuberculosis, pneumonia and other respiratory diseases, and diarrhea and other enteric diseases, show marked declines during this period. Using cause of death as a measure, three of the problems of greatest urgency have been addressed successfully, while two, accidents and mental illness, as reflected in the homicide and suicide death rates, have increased since 1955.

Using a services delivery system combining the public health and the

Table 9

AGE-ADJUSTED MORTALITY RATES
AMERICAN INDIANS AND ALASKA NATIVES IN RESERVATION STATES
AND SELECTED U.S. POPULATIONS BY RACE, 1980
(Number of deaths per 100,000 population)

	Indians and Alaska Natives	United States1/			Ratio of Indians to U.S.
		All Races	White	All Other	All Races
All Causes	621.4	585.8	559.4	774.2	1.1
Major cardioves. disease	178.4	256.0	248.4	313.5	0.7
Diseases of heart	142.4	202.0	197.6	234.2	0.7
Cerebrovascular disease	28.3	40.8	38.0	62.9	0.7
Atherosclerosis	3.8	5.7	5.6	5.9	0.7
Hypertension	2.2	2.0	1.6	5.3	1.1
Accidents	107.3	42.3	41.5	49.5	2.5
Motor vehicle	61.3	22.9	23.4	20.3	2.7
All other	46.0	19.5	18.0	29.3	2.4
Malignant neoplasms	76.4	132.8	129.6	158.2	0.6
Chronic liver disease and cirrhosis	43.0	12.2	11.0	20.0	3.5
Diabetes mellitus	22.6	10.1	9.1	18.8	2.2
Pneumonia and influenza	21.2	12.9	12.2	18.0	1.6
Homicide	18.1	10.8	6.9	35.0	1.7
Suicide	14.1	11.4	12.1	6.7	1.2
Chronic obstructive pulmonary diseases and allied conditions	7.7	15.9	16.3	11.5	0.5
Tuberculosis, all forms	3.6	0.6	0.4	2.4	6.0

1/Source of U.S. Mortality rates: Monthly Vital Statistics Report, NCHS, DHHS Pub. No. (PHS)83-1120, Vol. 32, No. 4.

medical models, the IHS in less than three decades has diminished the toll of communicable diseases and infant mortality to a remarkable degree. These feats have been accomplished through strong collaboration with Indian communities and a variety of other agencies, and through immunization programs, important sanitary measures, health education and an effective personal health care system. This strategy has recognized the critical importance of medical care, but has gone further to encompass a full range of factors significant for public health.

Recognizing the large behavioral and environmental elements in current health problems among Indians, it is clear that for them, as for other Americans, good health is correlated with the social and physical environments, life styles, economic and educational levels, and biological antecedents, and is only in part due to medical intervention after illness ensues.

We hope that this Program Review will develop recommendations that will assist the IHS in adapting its system of care to provide services more fully responsive to the needs of Indian people.

1. Health Services for American Indians, 1957 HEW Report, Section on Cultural Characteristics (pp. 16-19).

2. Shore, James H. and Manson, S., Overview: American Indian Psychiatric and Social Problems, Transcultural Psychiatric Research Review 20, 1983.

3. Markides, K. S., Mortality Among Minority Populations: A Review of Recent Patterns and Trends, Public Health Reports, May-June 1983.

History and Description of the Program

Background for Discussion II

During the earliest years of federally-supported health care, American Indians with symptoms of emotional or mental illness were diagnosed by general practitioners in Indian facilities or through contract arrangements and were institutionalized in off-reservation facilities, mostly state hospitals. Only one institution was devoted exclusively to the care of mentally ill Indians: an asylum in Canton, South Dakota, which was closed in 1933. Some of the Canton patients were transferred to St. Elizabeth's Hospital in Washington, but, where possible, the patients were transferred to state institutions.

Federal health services for Indians began under War Department auspices in the early 1800's. Article I of the Constitution provided the authority "...to regulate commerce with foreign nations, and among the several States, and with Indian tribes." In 1849 the responsibility was transferred to the newly created Department of the Interior, where the scope of services was gradually expanded.

Legislative Highlights

The authority of the federal government to provide health services to Indians is rooted in items from 25 USC 13, known as the Snyder Act, adopted in 1921. The charge of this Act was very broad, calling for the use of funds appropriated by Congress for the relief of distress and the conservation of health of Indians throughout the United States.

In 1955, Congress enacted the Transfer Act, Public Law 83-568, which established the Division of Indian Health and transferred these responsibilities from the Department of the Interior to the Department of Health, Education and Welfare. The Act reflected the scope of the federal health program for Indians, in somewhat more detail than the Snyder Act, in that it made specific reference to the maintenance and operation of hospitals and health facilities.

In 1957, the Department was authorized by P.L. 85-151 to provide assistance for the construction of community hospitals where it was determined that this was more effective than direct federal construction in making needed hospital facilities available to Indians. In 1959, P.L. 86-121 gave legislative form to IHS responsibilities for sanitation facilities and services, providing authority for domestic and community water systems, drainage, and sewage and waste disposal systems.

The Indian Self-Determination and Education Assistance Act, P.L. 93-638, was signed into law on January 4, 1975. This was the first major legislation affecting Indian health since the Transfer Act. Like the Transfer Act, P.L. 93-638 dealt with who would administer the Indian health program, rather than with its nature and extent. The Act authorized IHS to turn over the administrative responsibility for all or part of an IHS program to the tribe(s) served by that program, upon the request of the tribe(s), using the mechanism of contracting. The Act also authorized IHS to make grants to tribes for the planning,

development, and/or operation of health programs.

With passage in 1976 of the Indian Health Care Improvement Act, P.L. 94-437, the Congress took a major step in defining the scope of the Indian health program, expressing two major goals:

1. To ensure that the health status of Indian people is brought to the highest possible level, and

2. To achieve the maximum participation of Indian people in Indian health programs.

P.L. 94-437 is structured to address the backlog of unmet health care needs of Indian people in both reservation and urban settings and the maintenance of a system for providing health services of high quality and adequate quantity to these two groups. This Act, in conjunction with the Indian Self-Determination and Education Assistance Act, culminated almost a decade of effort to establish a framework within which Indian people can effectively determine their role in health programs. Congress provided the mechanism in P.L. 93-638, but relied on P.L. 94-437 and other authorities to provide the resources, to make Indian self-determination a reality.

Not only did P.L. 94-437 set forth the nation's goals for Indian health, but the Act also delineated for the first time in legislative language many of the programs and services already provided by IHS, as well as established a number of new programs. These new programs dealt with manpower, mental health, alcoholism, and the eligibility of IHS facilities for Medicare and Medicaid reimbursement. In addition, programs for urban Indians received a legislative base.

Developments from 1955 to 1964

The Transfer Act required the Public Health Service to prepare a report for the Congress describing the health status and health service needs of American Indians. The resulting report, submitted to the House Committee on Appropriations in February 1957, identifies mental illness as one of the seven most urgent health problems. The recommendation concerning mental health reads as follows:

> Mental health problems among Indians are evidenced by such manifestations as excessive use of alcohol, high incidence of accidents and violence, desertion, and juvenile delinquency. More service should be provided in an effort to meet the emotional and mental health problems among Indians, and a careful appraisal of need should be made.

Between 1955 and 1964, the services generally available to emotionally disturbed Indians continued to be mostly diagnostic evaluations and institutional care. With rare exceptions, inpatient care was still in state hospitals.

In addition to utilizing only state facilities for hospitalization purposes, a number of programs were developed in Division of Indian Health hospitals. For example, at the Phoenix Medical Center, therapy

was provided two days a week in family clinics by contract psychiatrists and hospital social workers. In addition, the Phoenix Area began to purchase short term hospital care from a private institution in Phoenix for patients with a more favorable prognosis. For long-term patients, the Phoenix Area used the state hospitals, as did the other Areas.

About the same time, the Alaska Medical Center in Anchorage also began purchasing some evaluative and consultative services from private psychiatrists to supplement the services available from the state mental health program. Long-term therapy in institutions was provided first under territorial and later under state auspices. The Division of Indian Health social workers in the Anchorage Hospital and later at Mt. Edgecumbe collaborated with the Alaska state mental health social workers and public health nurses to obtain social data and to prepare patients for treatment. Credit should also go to the Bureau of Indian Affairs, which provided much background information through the records of its Welfare and Law and Order Branches.

Other general hospitals which began developing regularly scheduled outpatient psychiatric services before 1965 were the facilities at Crow, Montana; Shiprock, New Mexico; Ft. Defiance, Arizona; and Tahlequah, Oklanoma. In addition to the psychiatric services provided on a regular basis to patients with emotional problems at the Division's hospitals, services were provided also by the Bureau of Indian Affairs social workers who served unmarried mothers, neglected or unwanted children, and maladjusted Indians not being seen at the Division's facilities.

The report of The President's Commission on Mental Illness, released in 1961, emphasized the need for comprehensive community mental health programs. "Comprehensive" was defined as including outpatient care and inpatient care near the home community, 24-hour emergency service, psychiatric consultation and training of staff, consultation to community agencies, rehabilitation services and aftercare in the home community, educational activities, and research and evaluation programs.

With the impetus of the national mental health movement, the Division of Indian Health gradually shifted from concentrating on sporadic clinical services to beginning the planning of a comprehensive mental health program.

The first break from a completely clinically oriented approach to mental health came at the Flandreau Boarding School in the Aberdeen Area. As early as 1956, it became evident to the Area Directors of the Division of Indian Health and of the Bureau of Indian Affairs in Aberdeen, South Dakota, that the aggressive behavior of some pupils at the Bureau of Indian Affairs Boarding School at Flandreau necessitated an overview of the emotional health of all of the boarding school students. A psychiatrist from Nebraska, Dr. Thaddeus Krush, was employed part time to make monthly visits to Flandreau to diagnose and treat the more troubled students, to hold classes for the school staff, and to consult with the superintendent and other staff members.

In 1964, the Association of American Indian Affairs (AAIA) held a con-

ference with IHS staff and outside consultants to discuss the two types of health problems then seen as most pressing for Indians: mental illness and otitis media. The conference lent support to plans begun earlier for a mental health pilot project in Pine Ridge, South Dakota.

Developments from 1965 to the late 1970s

The first mental health program in IHS began in 1965, funded with an appropriation of $100,000 for a pilot mental health project at the Pine Ridge Reservation in South Dakota. (As early as 1956, however, tribal representatives had requested a mental health program for the reservation population.) This project over time developed into the present mental health program of the Pine Ridge Indian hospital.

In December of 1965, the Surgeon General's Advisory Committee on Indian Health recommended that a similar project be established for Alaska Natives. In addition, Dr. E. S. Rabeau, then Director of the Division of Indian Health, diverted some funds originally allocated for solid waste disposal to support a mental health project for the Navajo Area. The Navajo project, at Window Rock, Arizona, began with the arrival of a psychiatrist, Dr. Robert Bergman, in July 1966.

Between FY 1965 and FY 1977, the program grew from an initial staff of five and $100,000 to a total of 223 positions and an appropriation of $4,240,000. In September 1976, Title II of P.L. 94-437, the Indian Health Care Improvement Act, included the following language authorizing specific types of mental health activities:

> (4) Mental health: (A) Community mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,300,000 and thirty positions for fiscal year 1979, and $2,000,000 and thirty positions for fiscal year 1980.
> (B) Inpatient mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $400,000 and fifteen positions for fiscal year 1979, and $600,000 and fifteen positions for fiscal year 1980.
> (C) Model dormitory mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,250,000 and fifty positions for fiscal year 1979, and $1,875,000 and fifty positions for fiscal year 1980.
> (D) Therapeutic and residental treatment centers: sums and positions as provided in subsection (e) for fiscal year 1978, $300,000 and ten positions for fiscal year 1979, and $400,000 and five positions for fiscal year 1980.
> (E) Training of traditional Indian practitioners in mental health: sums as provided in subsection (e) for fiscal year 1978, $150,000 for fiscal year 1979, and $200,000 for fiscal year 1980.

The congressional intent in authorizing these activities is summarized in the Indian Health Care Improvement Act Report of the House Committee on Interior and Insular Affairs to accompany H.R. 2525.

P.L. 94-437, as enacted, provided authorizations for three years of funding, 297 positions and $10,199,000, intended to supplement the funding level as of Fiscal Year 1977. This legislation was intended to

address unmet need for mental health services. It had been hoped that this legislation would make possible substantial improvements in boarding school conditions which lead to mental illness; acute short-term inpatient psychiatric care to meet the specialized needs of severely disturbed Indian patients; the establishment of a diagnostic, evaluation, and treatment center for disturbed and handicapped Indian children; the expansion of the field mental health programs of the IHS to reach communities not served; and the preservation of Indian healing traditions which have been serving their people well for centuries. Appropriations have permitted, but at a level well below that originally envisioned, the development of an inpatient short-term acute care facility, a children's diagnostic and therapeutic program, and additional resources for the boarding schools. The tables on the following pages reflect earmarked appropriations through FY 1983, nationally and by Area.

This legislation also authorized a new process in which tribes could prepare tribal specific health plans for submission to the Secretary or could ask the IHS to carry out this function on their behalf. Many tribes identified mental health services as a major priority. Lack of funding has prevented this process from leading to significant changes.

At about this same time, the Congress authorized funding for special attention to the needs of children who were deemed to be "Most In Need" (MIN). For FY 1980, Indian children were designated and a sum of $100,000 was allocated for the Indian Children's Program, both for its utilization and for distribution to Indian communities. Similarly, the Indian Children's Program received $71,400 in FY 1981 and $78,600 in FY 1982.

As a part of The President's Commission on Mental Health, there was a Special Populations Subpanel on Mental Health of American Indians and Alaska Natives. Their 1978 report to the Commission, entitled A Good Day To Live For One Million Indians, presented 18 recommendations, of which one calls for integration of services from BIA, IHS, and other sources.

By 1979, the Mental Health Program was serving an increasingly large number of tribal groups, with an authorized staff level of 287. About this time, however, the national and Area staffs were identifying problems that were also affecting the Indian Health Service as a whole and federal social programs generally. These problems stemmed from funding increases insufficient to compensate for inflation. We were therefore forced to leave an increasing number of positions vacant. As of the end of fiscal year 1983, IHS mental health staff had been reduced to 190 (plus 17 tribal employees using IHS mental health positions).

The Current Program

The mission of the IHS Mental Health Program is to provide and/or facilitate an accessible, efficient, culturally sensitive, and comprehensive mental health service delivery system which provides American Indians opportunities for maximum involvement in defining and meeting their own mental health needs and attaining the optimal level of personal well-being.

Table 1

INDIAN HEALTH SERVICE

History of Mental Health Program

	Appropriation	
	Authorized Positions	Dollars
FY 1965	Data Not Available	
FY 1966	5	$ 100,000
FY 1967	10	200,000
FY 1968	20	350,000
FY 1969	34	580,000
FY 1970	52	736,000
FY 1971	127	1,554,000
FY 1972	203	3,058,000
FY 1973	203	3,058,000
FY 1974	240	3,458,000
FY 1975	223	3,618,000
FY 1976	223	4,266,000
FY 1977	223	4,240,000
FY 1978	287	5,849,000
FY 1979	287	6,199,000
FY 1980	285	7,128,000
FY 1981	285	7,513,000
FY 1982	285	7,874,000
FY 1983	285	8,721,000
FY 1984	285	10,891,000

Table 2

ANNUAL APPROPRIATION ALLOCATION BY AREA - FY 1978 - 83

Mental Health Program
Indian Health Service

AREA	FY-83	FY-82	FY-81	FY-80	FY-79	FY-78
ABERDEEN	1,137,000	1,017,100	972,400	773,200	636,900	664,300
ALBUQUERQUE	911,000	745,500	778,100	630,000	663,000	738,300
ALBUQUERQUE - HDQTRS.	837,000	927,300	877,900	1,138,100*	689,700*	325,000
ALASKA	681,000	615,400	559,400	780,400	790,600	695,000
BEMIDJI	219,000	212,500	183,000	169,000	181,200	149,700
BILLINGS	845,000	735,000	717,200	655,600	580,500	575,600
CALIFORNIA	34,000	29,000	29,000	27,000	27,000	27,000
NAVAJO	1,033,000	919,000	806,700	812,700	757,900	708,300
OKLAHOMA	856,000	755,600	734,400	664,900	607,400	570,500
PHOENIX	835,000	747,800	679,400	851,800	719,800	691,900
PORTLAND	775,000	627,800	640,900	534,300	533,000	506,000
TUCSON	226,000	187,000	185,000	175,300	183,000	191,000
USET	389,000	355,000	349,600	329,500	321,000	283,000
T O T A L	$8,778,000	$7,874,000	$7,513,000	$7,541,800	$6,691,000	$6,125,600

* These amounts include the dollars for the Indian Children's Program and the Regional In-patient Program.

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The IHS Mental Health Program is a community-oriented clinical service comprised of an interdisciplinary staff network dealing directly with emotional and mental disorders of all levels of severity and the psychological and cultural aspects of health, well being, and illness. The programs are also concerned with institutions, communities, and social groups as they relate to the mental health of individuals. Providers within this service seek to respond sensitively and appropriately to individual and community needs related to mental health. Mental Health Program providers are an intregal part of the total health care team and, as such, strive to provide specialized services which are distinctive yet integrated into the available continuum of care. Specific objectives include:

A. Provide the highest quality of appropriate mental health services possible within the level of funding and personnel available.

B. Through formal and informal linking mechanisms, including intra-agency agreements, facilitate increased access to a full range of appropriate mental health services, keeping in mind the concept of the least restrictive environment.

C. Work with Indian communities and groups to design, implement and evaluate mental health promotion (prevention) activities. Assist tribes and native corporations to develop, staff, and manage their own community mental health programs if they so choose.

D. Work conjointly with other IHS clinical services in helping assure that the total health care needs of patients are properly addressed.

E. Serve as a federal advocate on behalf of Indian populations in mental health-related matters, including improvement of socioeconomic, housing, and educational conditions.

F. Develop and implement plans in respect to quality of care, third party reimbursements, contracts for mental health services under P.L. 93-638, training, research, continuing education, and general program management.

G. Serve as a source of data and information relating to the need for mental health services, workload statistics, and available resources to meet defined needs.

H. Respect and be sensitive to cultural and traditonal belief systems and practices as they relate to the mental health of individuals, families, and communities. Help sensitize personnel and other agencies and organizations who interface with Indian people to the importance of and impact that unique cultures and beliefs have on life styles and adjustment behaviors.

The national Office of Mental Health Programs in Albuquerque, New

Mexico, provides coordination, liaison with Headquarters East, and programmatic consultation for the Area Offices. The Areas each have a unit responsible for mental health, reporting ultimately to the Area Director. (The national and Area organizations are discussed in Section V, Organization and Funding.)

The types of services provided by the field mental health units include crisis intervention, some 24-hour emergency psychiatric services, outpatient services, limited inpatient admissions to general hospitals, referral and case management services, arrangements for voluntary and involuntary commitments to state hospital facilities, and outreach and community education.

The IHS operates only two inpatient psychiatric units, at Gallup, New Mexico, and Rapid City, South Dakota. The 9-bed inpatient unit at Rapid City, South Dakota, has been very favorably evaluated by a team which reviewed it in May 1983. The unit, which was funded at $379,000 in FY 1983, provides mainly adult inpatient care but treats a few day-care patients as well. The services provided are culturally sensitive and include referral to traditional healers. That there is need for expansion is illustrated by the fact that the waiting period for admission averages 2-3 weeks. The 13-bed unit at Gallup, New Mexico, which has an annual budget of $600,000, has operated at the current level for five years. It has a full-time staff of fifteen (one psychiatrist, six psychiatric nurses, and eight mental health technicians), plus a part-time psychiatric social worker and a part-time tutor. Approximately one-fourth of the Gallup patients are adolescents (ages 13-18) and typically one-third of all cases are admitted as emergencies. The average length of stay for adults is two weeks and for adolescents one month. Patients seeking elective care may have to wait several weeks, partly because of the capacity allocated to emergency cases.

The IHS Mental Health Program model calls for services to be carried out through teams of mental health professionals, strategically located throughout an Area, who train, supervise and back up the work of a larger number of Indian paraprofessional mental health workers. In addition to providing direct services, these professionals and paraprofessionals provide consultation services to Service Unit personnel, Bureau of Indian Affairs boarding schools, tribal governments, law enforcement agencies and other local organizations. The objective is to have at least one professional in each Service Unit and at least one Indian paraprofessional in each major tribal community, thereby maximizing the services of the team of professional and trained paraprofessionals. The model provides multiple access points to services. The mental health program based on this network of available services can be described as a program of support, constructive intervention, and prevention, planned specifically for the community it serves, with the advice and involvement of the leaders of that community.

Experience has shown two basic requirements for mental health work with Indian groups: a continuing effort to understand Indian

life, ideas, and language; and the participation of Indian people in the programs. In the local therapeutic milieu, community care givers and traditional healers can combine their efforts with IHS staff to bring about relief as well as reintegration into the community.

On the following pages are tables reflecting workload, by Area, for the three most recent years and distribution of mental health positions by Area.

Only about one cent of each health services dollar in the Indian Health Service is allocated to mental health. This compares with eleven cents spent on mental health in each national health dollar, seven to fourteen cents in each private health dollar, and 44 cents in each state and local health dollar (Report of the President"s Commision on Mental Health, 1978, updated to 1982 by Lewin and Associates, Inc., Cost and Financing of Mental Illness). Moreover, there is no evidence that incidence of mental illness is lower among Indian populations than in the U.S. population as a whole. Needs for preventive and therapuetic services have grown correspondingly with population increases. As noted above, when the IHS Mental Health Program was begun, there were half a million Indian people for whom it was responsible. Now, in 1983, that number has grown to three quarters of a million people residing in twenty-six states.

Results

Since the Program began, mental health staff have seen thousands of patients and/or arranged for care under contract with non-IHS providers or tribal organizations, and conducted countless preventive health and educational activities. After all this time, it might be logical to ask what positive difference this effort has made. One measure of program impact that is regularly used in evaluating public health program efforts is to measure the reduction in the incidence of problems in the population under scrutiny. We do not believe this approach to be productive in attempting to evaluate a mental health program effort. There is no unequivocal evidence for the premise that the incidence of mental health problems in any population can be significantly reduced by a direct services delivery system alone, even when that service effort appears to be adequate to meet the needs of the population. Moreover, we do not have acceptable base line measures of the incidence of the problems in Indian populations or an adequate system of data collection to make the appropriate comparisons, even if we could accept the premise.

We can, however, state that thousands of individuals have been helped to manage their lives more effectively and to understand their emotions and behavior more fully.

A considerable number of Indian persons have received training and employment as paraprofessional mental health workers and in some instances have gone on to become professionals after higher education.

Table 3

NUMBERS OF ALL REPORTED MENTAL HEALTH CONTACTS/ACTIVITIES

MENTAL HEALTH/SOCIAL SERVICE REPORT FORM (HSA-125-2) SUBMISSIONS BY AREA AND PROGRAM FOR FY-81, FY-82 AND FY-83

	FY-81				FY-82				FY-83			
	IHS	TRIBAL	NON-IHS	FY-81 TOTAL	IHS	TRIBAL	NON-IHS	FY-82 TOTAL	IHS	TRIBAL	NON-IHS	FY-83 TOTAL
Aberdeen	16,935	3,605	931	23,471	19,057	10,916	1,087	31,060	32,929	3,093	255	36,277
Alaska	8,500	-0-	-0-	8,500	10,650	-0-	-0-	10,650	11,230	-0-	-0-	11,230*
Albuquerque	11,151	-0-	-0-	11,151	17,290	-0-	-0-	17,290	20,014	-0-	-0-	20,014
Bemidji	11,092	-0-	-0-	11,092	6,320	6,096	-0-	12,416	10,693	-0-	-0-	10,693
Billings	13,747	-0-	-0-	13,747	13,921	-0-	-0-	13,921	17,248	-0-	-0-	17,248
California	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1,034	-0-	1,034
Navajo	26,697	-0-	-0-	26,697	25,501	-0-	-0-	25,501	25,089	55	-0-	25,144
Oklahoma	16,208	-0-	-0-	16,208	13,740	-0-	-0-	13,740	13,363	-0-	32	13,395
Phoenix	14,944	-0-	-0-	14,944	20,921	-0-	-0-	20,921	14,978	-0-	-0-	14,978
Portland	8,547	89	-0-	8,636	10,572	5,842	-0-	16,414	6,726	4,343	-0-	11,069
Tucson	-0-	-0-	-0-	-0-	-0-	146	-0-	146	-0-	-0-	-0-	-0-
U.S.E.Tribes	2,250	6,499	8,517	17,266	1,000	7,463	7,059	15,522	-0-	4,791	2,222	7,013
Hdqtrs-Indian Children's Prog.	5,110	-0-	-0-	5,110	3,779	-0-	-0-	3,779	2,407	-0-	-0-	2,407
TOTALS	133,181	12,193	9,448	156,822	144,751	30,463	8,146	183,360	154,677	13,316	2,509	170,502

Because of the unacceptable high error rates associated with our reporting, almost 30% annual/overall, we have opted to compile workload on the basis of number of records processed. Accordingly, we have tabulated the total number of processed records for each reporter who identifies his/her program affiliation as Mental Health for the year and compiled these by Service Unit and Area. Where possible, Tribal program staff reporting is compiled apart from IHS program staff.

While we have attempted to estimate a breakdown of the total records into patient contacts and project/other activities, the working assumption that the errored records were evenly distributed between these two uses appears to be too tenuous to support the estimates. We are assuming that all records that were processed were attempts on the part of service providers to document service related effort and that since these represent service contacts, the distinction between whether these are face-to-face, or "hands-on" contact with an identified patient, or contacts with other parts of the services delivery system directed at improving the level of services for a specific patient or class of patients, may be too fine a distinction to draw.

*PCIS plus estimate of contract services based on prorating workload statistics reported on Alaska State Mental Health MIS (contract projects use State MIS but are jointly funded by State and IHS funding).

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Table 4

TOTAL EDITED RECORDS OF MENTAL HEALTH CONTACTS/ACTIVITIES

WORKLOAD REPORTED BY GENERAL CATEGORY
MENTAL HEALTH 1975-82

PROBLEM CATEGORY	75	76	77	78	79	80	81	82
I. ALCOHOL-DRUGS	15.98	14.46	16.92	15.3	15.0	19.84	16.52	12.30
II. SUICIDE	2.89	2.68	2.71	3.91	2.25	2.35	2.03	2.31
III. MCH	3.21	3.24	4.12	5.26	4.84	4.06	4.09	3.76
IV. FAMILY SERVICES	6.59	7.92	6.4	7.35	7.32	5.71	8.19	9.01
V. CHILDREN & YOUTH	3.38	2.45	2.81	2.74	3.09	2.02	2.46	2.60
VI. INDIVIDUAL	35.12	34.30	35.0	34.96	32.29	34.99	32.28	35.46
VII. M.R.	1.11	.80	.36	.60	.50	.61	1.27	1.10
VIII. EDUCATION	3.13	2.42	2.21	2.04	2.64	2.02	2.81	2.24
IX. SOCIO ECONOMIC	5.10	4.6	4.43	4.35	5.11	4.37	4.33	3.68
X. EMPLOYMENT	1.52	1.37	1.0	.80	1.01	.91	1.02	1.08
XI. MED. LIAISON	12.95	14.95	13.58	12.85	12.33	11.53	11.22	11.91
XII. RESOURCE DEV.	.21	.19	.09	.14	.18	.15	.51	.30
XIII. SOCIO LEGAL	2.33	2.05	2.03	2.01	2.35	2.66	2.48	2.62
XIV. OTHER	5.14	5.79	6.22	6.26	6.67	5.97	6.40	7.24
XV. GENERAL	2.06	2.75	1.79	1.42	1.68	2.20	4.36	5.36
Total Records	47,259	55,087	51,438	60,353	58,854	54,009	85,938	102,007

Note: The fifteen general problem categories are ones that have been around since the early days of the RAC document and while they may be quarreled with we found it convenient to use them for this compilation. We used the quarterly reports to aggregate annual totals for all Mental Health Program reporters to get the totals, then because there are many problems with which Areas were reporting, the large increase during the past year, etc., we simply computed percentages of total reported as a first look at what was there. The FY 1975 and FY 1976 materials are adjusted to cover the current fiscal year period. We were somewhat surprised at the consistency in the distributions of reported effort over the seven year period. We could have almost been submitting the same records each year, with the minor fluctuations accounted for by the vagaries of the processing. These data, along with the consistency of the proportional amount of effort reported for Mental Health problems in the other major records systems seems to validate our contention that we're just "holding the line" with little or no room to adjust or re-focus.

Table 5

IHS Mental Health Programs
Filled and Vacant Positions FY 1981-83

	FY 1981				FY 1982				FY 1983			
	January 1981				February 1982				October 1983			
	Authorized	IHS	Tribal	Vacant	Authorized	IHS	Tribal	Vacant	Authorized	IHS	Tribal	Vacant
Aberdeen	48	32	9	7	46	26	8	12	47	30	8	9
Alaska	20	12	1	7	20	14	1	5	12	11	1	-
Albuquerque	34	26	4	4	31	23	2	6	34	20	1	13
Bemidji	8	7	-	1	8	6	1	1	7	5	1	1
Billings	31	27	2	2	31	25	2	4	31	24	1	6
California	-	-	-	-	-	-	-	-	-	-	-	-
Navajo	37	29	-	8	37	29	-	8	36	28	-	8
Oklahoma	30	28	-	2	30	25	-	5	30	24	3	3
Phoenix	24	20	4	3	22	19	1	2	20	14	-	6
Portland	28	16	5	7	28	12	5	11	28	19	2	7
Tucson	1	1	-	-	1	1	-	-	2	1	-	1
U.S.E.Tribes	2	2	-	-	2	2	-	-	2	1	-	1
ICP	11	7	-	4	11	6	-	5	11	5	-	6
OMHP	9	9	-	-	10	10	-	-	10	8	-	2
T O T A L	283	220	25	45	277	198	20	59	270	190	17	63
			245				218				207	

Authorized positions are those reported by Area Offices and do not reflect the number of authorized positions (285) shown by Headquarters, nor their distributions by Area. The February 1982 distribution was used to be consistent with Table 5 below. By the end of FY 1982 we actually had only a total of 206 positions filled (189 IHS, 17 Tribal).

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Table 6

IHS Mental Health Programs
Distribution of Staff by Discipline, FY 1981-1983

	FY 1981	FY 1982	FY 1983
Total Professional	114	101	93
Psychiatrist		17	16
Psychologist		31	25
Psychiatric Nurse		10	9
Psychiatric Social Worker		8	-
Social Worker		25	33
Other		10	10
Total Technician	94	76	73
Mental Health Technician		71	66
Social Service Rep./Aide		5	7
Total Support	37	41	41
	245	218	207

Important research has been conducted that may benefit the wider population, as well as Indians; the work concerning the fetal alcohol syndrome and the rehabilitation of Indian children with multiple handicaps are examples.

History of Relationships With NIMH

In FY 1972, memoranda were exchanged between the Office of the Secretary, the HSMHA Administrator, the Directors of the NIMH and the IHS, as well as the IHS Office of Mental Health Programs. Many of these communications had to do with the obligation of the Community Mental Health Centers (CMHCs) to provide services to Indian people and the need for IHS to pay for services provided on a fee-for-service basis.

Negotiations gradually broke down as the following problems became apparent: (1) IHS did not have adequate funds for reimbursement to CMHCs, (2) Centers were not geographically accessible to Indian clients, and (3) Centers were not being used by Indian people and were perceived as irrelevant to Indian needs. These discussions resulted in a decision that CMHCs must provide service to Indian people, but that IHS must further develop its own delivery system in light of the problems documented.

Over an 18-to-24 month period in the late 1970s there was active cooperation between IHS and NIMH to develop regulations recognizing Indian tribes as eligible applicants under the Mental Health Systems Act. These regulations reflected a significant achievement from the standpoint of the Indian community. Implementation did not occur because the Omnibus Reconciliation Act of 1981 placed the funding for community mental health under block grants.

In FY 1975, NIMH funded a minority research center, the National Center for American Indian and Alaskan Native Mental Health Research and Development, informally called the White Cloud Center. Originally located at the University of Oregon, the Center is now at the University of South Dakota.

Relationships with Other Programs and Departments

As discussed in Section III, Services for Children and Adolescents, the Office of Mental Health Programs has had a particularly positive and productive collaboration with the BIA in connection with the Indian Children's Program.

In addition, the Office of Mental Health Programs supports a small contract with the American Association of University Affiliated Programs to pay for a member medical institution to manage complex diagnoses of Indian children in their home locality. Following these services, a diagnosis and treatment plan is sent to the local service provider.

Services for Children and Adolescents

Background for Discussion III

Recently an Indian Health Service psychiatrist was invited by the Tribal Governor and officials of a southwestern Indian community to discuss the case of a young man who had a long history of drinking and deviant behavior in the community, who had become suicidal. As the discussion continued, the community officials each stated in vivid terms that there are many such young people in their community, that so far the attempts of the community to deal with these problems have been fruitless, and that they feel helpless. The sense of concern about the future of these young people and the future of the community came across clearly. All stated that something must be done and that help is needed.

1980 census figures indicate there were approximately 373,000 Indian children and youth under the age of nineteen years and that Indian children and youth represented 45 percent of the Indian population eligible for IHS services. This segment of the Indian population is growing at an estimated rate of 3 percent per year. Traditionally, children are an important focus in Indian communities, and concerns about their children and youth are paramount today.

In this section we shall look at the ways in which mental health concerns pertaining to Indian children and youth have been viewed both in a historical sense and more recently. We shall describe Indian Health Service efforts to respond to these concerns and shall look at ways in which these responses are changing. Finally, we shall explore some current issues pertaining to mental health programming for Indian children and youth.

For the purposes of this discussion, mental health concerns include a broad range of psychological, physical, and social variables and their impact on the psychological functioning of young people. These variables may be manifested in an equally broad range of presenting problems, including for example child abuse and neglect, behavior problems, depression, psychosis, learning disabilities, and substance abuse.

Likewise, mental health services include a wide range of interventions provided by a variety of caregivers. Interventions include direct and indirect clinical services and therapeutic and preventive activities. Interventions may occur at the individual, family or community level and may take place at home, in the school, in an office, or in a hospital setting.

Statement of the Problem

Until about 1976 mental health concerns pertaining to Indian children and youth were focused on a few glaring problem areas. Boarding school problems are frequently mentioned in the literature. The 1957 HEW report, Health Services for American Indians, refers to "child abandonment" as a special mental health problem and describes the negative impact on children and families of alcohol abuse in the family. Toward

the end of this period, concern was expressed regarding the negative effects of placement of Indian children with non-Indian families away from their home communities. Recommendations were problem specific and focused only on ameliorating the presenting problem. In the literature of this period, mental health issues pertaining to children and youth usually are not conceptualized separately from those of the general population.

This trend began to change in the early-to-mid 1970s with a growing awareness of children's issues nationally and an emerging conceptualization of children as part of a family system. Within Indian communities concern regarding children and youth increased with an apparently rapid rise in the incidence of suicidal behavior and alcohol abuse among children and youth. In an article on Suicide and the American Indian (1), the theme of social disorganization and family breakdown associated with rapid change and cultural conflict was discussed. This theme is continued in a paper by Westermeyer (2): "Indians with a low cultural identity are more likely to have social problems, be imprisoned, or suffer mental illness". The Report of the Special Populations Subpanel on Mental Health of American Indians and Alaska Natives to The President's Commission on Mental Health raised similar concerns and emphasized the need to support "the natural support systems" of family, clan, community, and tribe within Indian communities. (As noted earlier, this Report is included in the Appendix.)

Save the Children Foundation has sponsored four National Indian Child Conferences (1978, 1979, 1981, 1983). All the conferences have been well attended and have helped to focus attention on the special needs of Indian children and youth. Mental health issues, including discussions of treatment and prevention approaches, have been prominent, and conference resolutions have supported the need for increased Indian mental health services.

The Bottle Hollow conference on Supportive Care, Custody, Placement, and Adoption of American Indian Children (1977) sponsored by the American Academy of Child Psychiatry, with cosponsors including the Association of American Indian Physicians, the IHS Office of Mental Health Programs, the National Association of Indian Social Workers, and the Association of American Indian Affairs, focused on innumerable child welfare problems. The conclusions emphasized that with the loss of Indian heritage "is a concomitant lowering of individual and collective self-esteem, without which Indian children grow up destined for identity confusion and general failure both as self-sufficient adults and as parents." A vital theme of the conference, therefore, was the call for affirmation of tribal heritages and the retention of cultural ties too often severed by the unwarranted placement of Indian children in non-Indian homes and schools. The Warm Springs conference on A Case Study Approach to Recognizing the Strengths of American Indian and Alaska Native Families (1979), also sponsored by the American Academy of Child Psychiatry, cosponsored by the National American Indian Court Judges Association, again looked at family disorganization and advocated a family approach coordinating already existing resources with a multidisciplinary effort.

The President's Commission on Mental Health Sub-Task Panel on Infants, Children, and Adolescents (1978) highlights some of the special program needs and concerns for children and youth:

> Services must reflect ways in which children's needs differ from those of adults. While the traditional goal of adult therapy has been to return the individual to his previous level of functioning, a child, on the other hand, must be restored to normal patterns of growth and aided in compensating for lost development. . . Treatment must address the course of the illness and include counselling for parents and other adults in the child's life. . . Mental health services for children must also be delivered within a system of care that insofar as possible promotes and maintains a continuing relationship between child and family. . . Mental health services should also be organized along a spectrum so that a given child can move in any direction as the treatment needs of the child change.

The report goes on to emphasize the critical role of prevention when dealing with children and development and recommends a balance of resources devoted to therapeutic and preventive services.

There have been two important pieces of federal legislation pertaining to Indian children and youth that have reflected and reinforced the trend to special programming for the needs of young people and have emphasized the role of the family and community. As noted in Discussion II, the Indian Health Care Improvement Act of 1976 authorized:

> (C) Model dormitory mental health services: sums and positions as provided in subsection (e) for Fiscal Year 1978, $1,250,000 and fifty positions for Fiscal Year 1979, and $1,875,000 and fifty positions for Fiscal Year 1980.
> (D) Therapeutic and residential treatment centers: sums and positions as provided in subsection (e) for Fiscal Year 1978, $300,000 and ten positions for Fiscal Year 1979, and $400,000 and five positions for Fiscal Year 1980.

It was understood that these treatment centers were intended for children and youth.

The Indian Child Welfare Act of 1978 defined the manner in which Indian child welfare and child custody cases would be adjudicated and required that the Indian family and community be the primary focus in such adjudication (3).

Indian Health Service Efforts to Address the Problems

Until the Indian Health Service Mental Health Program was established in 1966, mental health and mental health issues pertaining to children and youth received little attention. With the establishment of the IHS Mental Health Program, individual IHS staff became increasingly concerned with issues pertaining to children and youth, but efforts at intervention remained limited and the program maintained a more general mental health focus. The Model Dormitory Project, begun at Toyei, Ari-

zona in 1969 demonstrated that a boarding school utilizing more and better surrogate parents resulted in marked benefits for the boarding school children.

> Tests of intellectual development showed that the model dormitory children, especially the boys, performed better than those in the control school. Teacher ratings indicated that model dormitory girls worked harder, persevered longer in a job, and paid more attention to directions than did the controls. Model dormitory children had fewer negative emotional indicators on tests of emotional development (4).

Several suicide intervention projects were implemented in the Billings and Portland Areas in the late 1960s and early 1970s. In 1969 a suicide prevention center was established at Fort Hall, Idaho, utilizing both professional staff and Indian volunteer counselors. Young people considered at risk for suicide were referred to the program. The project was considered a needed alternative to the existing legal system's use of incarceration for youth at risk (5).

> In the eighteen months after the creation of the suicide prevention center there were no suicides in the age group under twenty-five years whereas, based on data from the previous seven years, two or three suicides below the age of twenty-five could have been expected (6).

With the passage of the Indian Health Care Improvement Act in 1976, the Indian Health Service became directly and actively involved in providing clearly defined but limited mental health services to children and youth for the first time. With the allocation of $114,000 and 6 positions (a marked decrease from the 437 authorization levels), a new model dormitory project patterned after the earlier successful Toyei project was started at the Stewart Indian School in Nevada in 1977. This was designed to be a "flexible program that will accommodate innovation in program areas identified in home living, recreation, counselling, academic, cultural, and therapeutic areas based on the identified needs of the students and staff at Stewart Indian High School" (BIA/IHS Memorandum of Agreement, 1979). This project was developed as an example of BIA/IHS interagency cooperation, but unfortunately the project was ultimately undermined by unresolvable inter- and intra-agency conflicts, and with the BIA decision to close the Stewart Indian School in 1980 the funding for the small model dormitory effort (a little over $100,000) was divided between the Chemawa Indian School in the Portland Area and the Albuquerque Indian School, which the respective Areas agreed to match.

The model dormitory effort at Chemawa has continued with a therapeutic recreation program with two recreation therapists. The program utilizes recreation activities as a way to help students confront and work through emotional/behavioral difficulties. The Albuquerque program, which transferred to the Santa Fe Indian School in 1982, has had two foci: (1) the development and implementation of a "Student Living Guide", a health promotion curriculum of lectures, discussions, and activities to be used in the dormitories, and (2) an "Independent

Living" program consisting of a small group home for selected students with an emphasis on individual and group responsibility.

The Indian Children's Program

The Indian Children's Program (ICP) was another development from the Indian Health Care Improvement Act. Originally, the Indian Children's Program was conceived as four or five regional residential centers and community support outreach teams located strategically throughout the IHS service area. Funds were never appropriated for residential centers. The first outreach team was established in Albuquerque in 1978 as a joint Indian Health Service/Bureau of Indian Affairs effort and was designed to provide individual evaluation and treatment of academically, emotionally, physically, and mentally handicapped children; technical assistance support for local home service providers; and individual and community education activities concerning handicapping conditions. The current staffing level consists of 8 IHS employees and 12 contract employees supported by a combination of IHS and BIA funds.

The southwestern regional program continues to be a successful interagency activity meeting the needs of handicapped children and their families in terms of individual evaluation and treatment planning, consultation with local human services agencies, and general educational activities concerning care of handicapped children. In addition to providing high quality, reliable human services to the families in the region, this program has demonstrated that IHS and BIA/OIEP (Office of Indian Education Programs) can successfully collaborate on activities benefitting handicapped children. Because of financial constraints, plans for a southwestern residential center as well as plans for the other four regional programs have been deferred.

The ICP provides services to and works with BIA schools and dormitories; tribal, public and parochial schools that serve Indian children; Headstart programs; IHS hospitals and clinics; BIA, tribal, state, and county social services programs; other mental health programs that need child consultation; tribal and district courts; juvenile probation and law enforcement programs; alcohol and substance abuse programs; tribal health planning groups; and so on.

In addition to providing direct and consultative clinical services, the ICP provides training to staffs of various programs that work with children. It also assists communities in the Albuquerque and Navajo Areas in developing their own program efforts. The ICP has assisted communities such as Hopi, Mescalero, and Zuni in developing and obtaining funding for juvenile first offenders programs, foster grandparents programs for handicapped children such as at Zuni, a drop-in center, a youth advocacy committee, and interagency child protection teams.

The Fetal Alcohol Syndrome Project

The Office of Mental Health Programs established a special Fetal Alcohol Syndrome Project in late 1979 as part of the International Year of the Child. This initial project continued until 1982 and has had a major impact on sensitizing health care staff and community members to

the fetal alcohol syndrome (FAS) and the need for increased prevention efforts regarding alcohol misuse. In all, the FAS Project trained over 11,000 Indian health care providers, educators, and citizens in the recognition and prevention of fetal alcohol syndrome. In addition, over 240 children were seen in 24 clinics and 115 fetal alcohol-affected children were identified. The epidemiology of FAS indicated wide variation in incidence among the southwestern tribes, varying from 1 FAS child per 750 births to a high of 1 per 100 births.

In Fiscal Year 1983, the Congress recognized the need for further FAS efforts and allocated additional funds to the IHS alcohol program for a nationwide prevention project. In September, HRSA awarded a new contract for $213,000 to the All Indian Pueblo Council, Inc., to begin the National Indian Fetal Alcohol Syndrome Prevention Program. Its mission is to train a minimum of 6 trainers in each of the IHS Service Units from Alaska to Florida. These trainers will be from IHS, the BIA education system, and tribes. They will serve as the nucleus of an ongoing network for FAS activity for all Indian people (7,8).

Other Activities for Children

A further example of Indian Health Service/Bureau of Indian Affairs cooperation occurred with the establishment of the Interagency Agreement of 1980 providing for the mutual sharing of costs for residential treatment of mentally disturbed patients. In practice, this agreement applied almost entirely to children and youth. Implementation of this agreement was difficult because of intra-agency conflict and the continued limitation of contract funds available for residential treatment, and the agreement was terminated in 1982.

At the present time, Indian Health Service mental health staff are witnessing a marked increase in problems of children and youth. While the Indian Health Service data are sometimes difficult to evaluate, as the Mental Health/Social Service data system does not capture much needed information, the direction of the data is clear. In fiscal year 1982, services were provided to a reported 27,283 Indian children and youth under nineteen years of age by Mental Health and Social Services staff. This figure represents 22 percent of the entire Mental Health/Social Services caseload. Between 1977 and 1982, there was a three-to-fourfold increase in reports of child neglect and abuse, depression in children and youth, alcohol misuse in children and youth, school behavior problems, and suicide attempts in children and youth. In 1982, 652 suicide attempts were reported for age nineteen years and under; whereas, using national suicide prevalence rates, approximately 448 suicide attempts might be expected in a population of similar size and age. In Drug Use Among Native American Youth: Summary of Findings (1975-1981), Drs. Oetting and Beauvois report:

> Indian adolescents in grades 7-12 have a higher level of exposure to every drug that was included in the survey. Inhalents are tried more often by Indian young people. Indian youth use alcohol more heavily than non-Indian adolescents. Drug use has increased steadily among Indian youth since 1975. Much of this increase has occurred during recent years.

The Report of the Special Populations Subpanel on Mental Health of American Indians and Alaska Natives of The President's Commission on Mental Health also emphasizes the magnitude of alcohol-related problems among Indian people and the impact of such problems on young people, including child neglect and abuse, an increase in juvenile delinquency, rape, suicide, unwanted teenage pregnancies, and school dropouts. In a recent survey of community providers in the Albuquerque Area (with a population of about 25,000 Indian children and youth), over one hundred children and youth have been identified as needing intensive psychiatric services. This figure is probably several times that expected for a population of this size. As indicated at the beginning of this section, community members are alarmed and feeling overwhelmed by the number of troubled young people.

The Indian Health Service provides significant levels of medical services to Indian children and youth. In fiscal year 1982, IHS reported over 345,000 outpatient contacts with children and youth through age nineteen years. Many Service Units have pediatricians and the larger hospitals provide pediatric wards. An organized Maternal and Child Health Program has had a major impact on assuring high immunization levels among young children. Mental health services to children and youth, however, are the exception rather than the rule. In a recent poll of Indian Health Service Area Mental Health Branch Chiefs, all indicated that the standard practice in their programs is for children and youth to be managed as part of a worker's general caseload.

There are few children's mental health specialists in the Indian health Service other than with the geographically restricted Indian Children's Program. There are no IHS-operated residential treatment facilities for Indian children and youth with psychiatric disorders. Access to treatment facilities outside of the Indian Health Service is usually limited due to jurisdictional and financial restrictions. In many IHS Areas, mental health consultation is provided to day schools and boarding schools, but again these services are limited. Mental health consultation to IHS pediatric services is likewise limited.

As indicated in the Report of the Task Panel on Mental Health and American Families: Sub-Task Panel on Infants, Children, and Adolescents, if one is concerned about children and development, one must be concerned about prevention, and therefore the focus is potentially on all children. Mental health services should help "children to develop a free and positive sense of self, to prize curiosity, and to delight in their own accomplishments." Within Indian Health Service there has been an increased interest in prevention activities since the publication of the Surgeon General's report, Healthy People, in 1979. Although prevention efforts within the Mental Health Programs continue to be minimal, there are some projects of interest.

In the Albuquerque Area, the Mental Health Program has contracted with the Albuquerque Area Indian Health Board to provide a parenting project for the Ramah Navajo Community. This project focuses on high risk young parents and combines a self-help approach with health education. Another recent contract with the Artists of Indian America, Inc., involved a week-long workshop with youth in their school setting. The workshop utilized music, dance, drama, and poetry to help increase the

self-esteem of the young people involved in the workshop and to provide a variety of new, positive role models.

In the USET Area, the Seminole Tribe using IHS funds has developed an Indian Medicine Program focusing on helping young people at risk obtain a positive sense of identification with their culture.

In the Navajo Area, much work has been done utilizing the Brazelton Newborn Infant Assessment Scale in screening newborns for physical and developmental disorders and as an aid in promoting maternal-infant bonding.

The Mental Health Program clearly recognizes the need for specialized mental health services for children and youth and the need for a system of prevention and intervention focused on the family and community.

Current Issues/Definitions

As seen above, there are or should be many participants involved in the planning and provision of treatment for children and families with mental health problems. In addition, it would seem that there is a great deal of fragmentation of programming efforts, even though there appears to be both a need and a desire for a more specialized, focused approach to both intervention and prevention. Depending on the circumstances of the referral, a variety of programs, representing a number of agencies and jurisdictions as well as specific discipline-oriented approaches to problem solving, may be involved with a single case--all appropriately so.

As an example of this, it is possible to have at a single case conference the child and his family, a representative of one or more social service agencies, tribal court, juvenile probation, IHS mental health, IHS community health nursing, one or more school personnel, a physician, and so on.

Each individual or program is dealing with a piece of the child's problem and views it from a particular orientation or perspective. Depending upon the community, some of these individuals may be paraprofessionals or have little training or experience working with children or families presenting complex, difficult problems. It becomes apparent after encountering this type of situation again and again that several urgent issues emerge.

One issue is how to develop and utilize the strengths and resources of the Indian family and the community in which it resides. Providing support and direct assistance to the family within its own community would seem to be the most effective way of dealing with many presenting problems. In order for this to occur, one must deal with the issues of networking or establishing functional linkages between programs. Community development, i.e., developing and nurturing local resources to address the problems of children and families, becomes another issue to be dealt with. Low population density, large distances to be traveled, and lack of personnel willing to live and remain in these areas for a long time are all factors that make this situation more difficult to deal with.

At the present time, mental health programs that do exist in the Indian communities are few in number, are understaffed or lack trained staff, and have little in the way of support or specialized consultation available to them. Mental health consultation should be provided on an ongoing basis and should be both patient-centered and address program issues. Its purpose should be to improve patient care by improving provider skills, as well to provide support to community-based staff. In addition to consultation, formalized training in specific areas of children's mental health should be provided regularly. Where professionals are difficult to recruit and retain, itinerant services supporting paraprofessional indigenous workers may be the necessary solution.

When these issues are addressed adequately one then may have the foundation for a system of care, and it becomes obvious that one must approach the problem of the care of children with mental health problems in terms of systems: health and mental health systems, social services systems, educational systems, judicial and law enforcement systems, tribal government systems, county and state government systems, federal government systems, and so on. It then becomes necessary to develop a methodology to facilitate an integration of these systems so that easy communication and cooperation can be developed.

At the same time, one must look at the mental health system itself within IHS to see how it currently deals with the problems of children and their families. Of course, there is great variation among the Area and Service Unit programs in how they deal with children's mental health problems, but in general it is probably safe to say that there is no service-wide system of care that provides an integrated continuum of services for children with various levels of need.

Such a system would include access to inpatient or residential resources for the most seriously disturbed children, to transitional or intermediate facilities at the community level for children who are being prepared to return to their communities or who need one step below hospitalization, and to outpatient/community-oriented services for children and families who are being treated within the community or who are returning to the community. The latter can provide consultation, support and training to community-based programs. Such a system would be staffed by individuals who are trained child specialists, who are equipped with the special skills needed to accomplish the necessary tasks, and who can provide a core or a framework around which the various needed services can be integrated, coordinated, and monitored. The need for inter- and intra-agency integration of the multiple services that many emotionally disturbed children and families require is self-evident, to streamline and help avoid duplication or omission of required services.

A system working cooperatively with the tribes, with a clear mandate, would be better able to deal with interagency as well as the various legal jurisdictional problems that regularly arise in the area of mental health care for Indian children. It would be available to assist tribes with the development of such things as children's codes, tribal programs, standards of care, and other related issues as they emerge.

A system of care such as the one being discussed would involve a considerable investment in money and manpower to provide a high quality program. At the present time, such manpower and funds are not available for a concentrated effort. Indeed, it is quite difficult at the present time even to provide for residential care for a minimum of children currently in need.

Prevention is another area that requires considerable effort and attention. Many tribal leaders and elders are appalled at the problems currently facing Indian children and youth. They have expressed interest and support for programs that can prevent many of the serious problems that mental health staff all see and deal with. Community education programs, early intervention efforts, and systemmatic program-oriented research are well received by tribal leadership. Continued and greater efforts in these areas are necessary and could lead to reduced costs for care and treatment as well as reduce the pain and suffering experienced by so many Indian children, families and communities.

1. Dizmang, L.H., Watson, J., May, P.A., Bopp, J., Suicide and the American Indian, Psychiatric Annals 4(9), 1974, pp. 22-28.

2. Westemeyer, J., "The Ravage of Indian Families in Crisis" in The Destruction of American Indian Families, edited by Steven Enger, Association of American Indian Affairs, New York, 1977.

3 The Indian Child Welfare Act of 1978: Provisions and Policy, from The South Dakota Law Review, Winter 1980.

4. Goldstein, G.S., The Model Dormitory, Psychiatric Annals 4 (9), 1974, pp. 85-92.

5. Shore, J.H., Bopp, J.F., Waller, T.R., Dawes, J.W., Suicide Prevention Center on an Indian Reservation, American Journal of Psychiatry 118, pp. 1086-1091, 1972.

6. Dizmang, L.H., Watson, J., May, P.A., Bopp, J., ibid.

7. May, Philip A. and Hymbaugh, K., A Pilot Project on Fetal Alcohol Syndrome Among American Indians, Alcohol Health and Research World, Winter 1982/1983.

8. May, Philip A. et al., Fetal Alcohol Syndrome Among American Indians of the Southwest, Social Biology 30 (4), 1983.

Evaluation and Research Findings: Needs for Evaluation and Reporting System

Background for Discussion IV

Before appropriate program evaluation can be carried out, certain elements must be in place. These include clear statements spelling out program goals and objectives, as well as explicit organizational, operational and service standards. While the former have been available, consensus on the latter has been difficult to reach. In addition, a number of factors lead to great variability in the mental health programs across Areas and, therefore, make systematic evaluation more difficult than it might otherwise be. These factors include differing combinations of resources availability, interest and service priorities, tribal funding, state concerns, the range of service delivery modalities (e.g., field clinic, hospital-based, outpatient, inpatient, etc.), and a host of other factors involving remoteness, geographical distribution, communications, climatic conditions, and such things as federal and state law.

Evaluation of the efficacy of specific mental health programs as well as that of psychotherapy in general is extremely difficult for a number of reasons. The difficulty lies in the natural bias of the observer who makes the evaluation. Thus, organized psychiatry supports credentialing, while the issue of accountability is of paramount importance to those third party agencies funding mental health programs (The Effect of the Method of Payment on Mental Health Care Practice, Group for the Advancement of Psychiatry Report No. 95, Volume IX, November 1975).

Evaluation Findings

There has been one national evaluation of the Mental Health Program: a 1974 descriptive study that could have served as the base line for subsequent outcome evaluations. The final report by Carolyn Attneave and Morton Beiser (1) describes the development and early operation of the Mental Health Program in separate volumes for each of eight Areas. The authors presented approximately 80 recommendations in their Overview and Recommendations volume. Subsequent national studies have not been carried out, partly because of lack of sufficient funds and lack of valid data on which to build evaluations.

There have, in addition, been several evaluations of mental health programs in particular Areas or on an individual reservation.

A systematic effort to develop criteria for program evaluation was involved in the management support team visits to individual Areas. From 1979 through 1981, review teams, typically composed of two representatives from the Office of Mental Health Programs staff and one Area Mental Health Branch Chief, began to carry out reviews of Area Mental Health Program activities using mutually agreed upon criteria. Each of the Area programs was to be reviewed biennially, and each cycle through the process would guide, clarify and refine both the definition and the appropriate content of the program elements to be involved in the reviews. The effort was thought of as dynamic and adaptive, gradually

accumulating and synthesizing a body of program standards that could realistically be generalized to include all Area and tribal program efforts. These reviews were suspended in FY 1982 due to financial and staff limitations.

The visits were designed to collect and disseminate information about the Area programs, to collaborate with the Area Mental Health Branch Chiefs in dealing with problems of administration, planning and maintenance of mental health programs, and to create a process of communication that would facilitate the sharing of common goals among all Areas. The teams' work was guided by a uniform checklist.

These visits were helpful in evaluating program accomplishments, reviewing and strengthening, where needed, administrative practices, keeping the Areas and Office of Mental Health Programs staff in touch with program developments and concerns, and identifying successful approaches that might be duplicated elsewhere.

Mental Health Research

Very little in the way of resources is formally available for research efforts by program staff within IHS. The one percent commitment authorized by P.L. 94-437 has, for the past five years, been used in a project located in the Santa Fe Indian Hospital addressing the effectiveness of biofeedback in treating alcohol disorders, entitled Self-Mastery and Coping Skills Training Project.

Even though few resources are available directly for internal research efforts, a number of significant projects have developed from collaborative endeavors with university programs, including most prominently those conducted through the White Cloud Center (the National Center for American Indian and Alaskan Natives Mental Health Research and Development) and the Oregon Health Sciences University. (See especially the White Cloud Journal, Vol. 2, No. 2, 1981, in the Appendix.) Subsequent research efforts that developed at least partially from this collaboration range from detailed studies of the epidemiology of depression among American Indians to the epidemiology of mental disorders among American Indian children. The Indian Children's Program played a significant part in developing two other noteworthy projects, studies of epilepsy at Zuni, Tuba City and Keams Canyon and preliminary testing with the System of Multicultural Pluralistic Assessment (SOMPA) in southwestern Indian populations. Projects like the study of Civil Commitment of American Indians by Bloom, et al. (2), and the ongoing studies of drug use among American Indian adolescent populations in the Southwest by Oetting, et al. (3), grew out of shared concerns about these significant issues. The preliminary research on FAS and the follow-up on this project have involved the mental health staff.

In these collaborative efforts, the Office of Mental Health Programs has consistently attempted to require that the researchers keep pragmatic programming considerations in the front of their minds, seeking practical applications of what they are learning . One distressing example of how difficult it is to sustain this concern can be seen in the efforts to demonstrate that a little bit of intervention

goes a long way in the boarding school setting. In two separate, carefully documented research efforts (Krush, et al. (4), in Flandreau, South Dakota, and Goldstein, et al. (5), at Toyei, Arizona), it was unequivocally demonstrated that a minimal amount of caring could significantly affect the social, emotional and educational growth of Indian children perforce domiciled in boarding school settings. These data were used to justify the language contained in P.L. 94-437 (c)(4)(C) which addressed these issues. Using funding under this legislation, it was demonstrated that the knowledge could be systematically integrated as a program element at Stewart Indian School in Nevada. However, because of a variety of circumstances, the IHS has been essentially unable to maintain this effort in more than one location for any sustained period of time. In this instance we know what needs to be done, yet in spite of this clear knowledge we have been unable to integrate the approach systematically into our service delivery system. Unfortunately, this is only one example of a class of issues involved in applying what we learn, or already know.

Data Sources and Processing Capacity

One of the key issues in developing adequate and appropriate measures for mental health program evaluation revolves around acquiring accurate and dependable measures of various kinds relating to these programs' operations. It would be reasonable to expect that these data might be routinely available from the agency's reporting system. In this case, "routinely", rather than "available", is the operative word that gets in our way.

Probably the key criticism of the current aggregate collection of record keeping is that it is a considerable task to derive information, services or demographic data, organized around individual patients, which will allow the investigator to systematically get past the often misleading workload information generated from the separate records systems. For example, deriving reasonably accurate estimates of incidence or treated prevalance from reported demand on the health care systems should be an important output, but often becomes a complex task because of the ways the data are organized. The difficulties in identifying the number of people making the demands, or the related problem of identifying the total workload, from all or selected services provided to a single individual during one episode of illness, have led us to make some rather strange, even absurd, statements about the scope and nature of the problems we are attempting to deal with, as well as what we are doing about them.

The current reporting system for the Mental Health Program was implemented in 1973 as a pilot project. It is a shared system in that two programs, Social Work Services and Mental Health Programs, are using the same input document, processing procedures and reports generated as output, yet some attempt is made to separate the data so that each program's efforts are shown separately. The input document was designed by a committee that could never resolve a basic difference of opinion as to whether the record should primarily capture information about staff activities or about patient care. As a result it does neither very well. The data processing involved use of the mark sense forms and an optical mark page reader, procedures which were already obsolete in 1974.

The report writing programs that generate the outputs were a "first cut" on a barely operating system and are in some ways exemplary of the whole project, because they were "fixed" before we even understood the capabilities, or lack thereof, of the system. (A copy of the Social Services and Mental Health report form follows this page.)

The system was supposed to be dynamic, with revisions as both the system's operational characteristics and our information requirements were clarified. No changes in the system have been made since its initiation. Numerous requests have, however, been made to do so. In part, proposed changes have been disapproved because of an earlier plan to convert all program reporting to the Patient Care Information System. Other factors were the lack of a coordinated MIS or ADP master plan in IHS.

In FY 1982, the Data Processing Service Center proposed to shift all records systems using mark sense forms to key entry forms, citing the numerous problems associated with the off line processing using the Optical Mark Page Reader. While we concur that this system of processing has created some of our problem, simply correcting this part of the situation will not address the larger problem, that of an inadequate input record. This solution will get only more weak records past the edit programs, and while it would solve some of Data Processing Service Center's problems, it would not solve ours.

While the Social Services and Mental Health form is the most widely used report, not all Areas report on this system. Currently:

1. Nine Area and Program office programs (Aberdeen, Bemidji, Albuquerque, Oklahoma, USET, Portland, Phoenix, Navajo, and Tucson) use, to some degree, the Social Services and Mental Health report form;

2. Two Area programs (Alaska and Billings) report on the ambulatory encounter records of the PCIS;

3. One Program office (USET) uses a modified version of the SS and MH form for contracted program reporting;

4. One specialty program (Indian Children's Program) uses an even more highly modified report to document their activities and patient contacts in four Areas;

5. Several contracted programs use their own systems of information collection and collation which we (IHS) may or may not be receiving routinely; and

6. One Program office (California) has only recently begun to send reports routinely to the Office of Mental Health Programs.

Apart from the obvious issues associated with attempting to derive meaningful data from such a disjunctive system, the SS and MH reporting system needs:

HSM 7 5 2 (PAGE 1)
12 73

SOCIAL SERVICE AND MENTAL HEALTH REPORT

COMPUTER COPY – FOR USE WITH MASTER MARK FORM 15

1. PROJECT NUMBER

2. PATIENT IDENTIFICATION

SSg – MARK ALL NINE LINES
HRg – MARK LINES FOUR THROUGH NINE

3. COMMUNITY OF RESIDENCE OR PROJECT LOCATION

HUNS
TENS
UNITS

4. AGE

UNDER 28 DAYS
28 – 364 DAYS
IF ONE YEAR OR OLDER, INDICATE AGE IN YEARS
TENS
UNITS

5. SEX (MARK ONE)

MALE
FEMALE

6. CONTACT CATEGORY (MARK ONE)

INITIAL CONTACT
RE-CONTACT
NON-CONTACT (REGISTER UPDATE)

7. CONTACT CLASSIFICATION (MARK ONE)

IHS INPATIENT
IHS OUTPATIENT
CONTRACT INPATIENT
CONTRACT OUTPATIENT
FIELD
OTHER

8. CASE REGISTER

DELETE FROM REGISTER

9. DIAGNOSIS – ICDA CODE (FOR DESIGNATED CONSULTANTS ONLY)

HUND
TENS
UNITS
DECIMAL

10. PRIMARY PROBLEM CODE

TENS
UNITS

11. SECONDARY PROBLEM CODE

TENS
UNITS

12. PRIMARY PURPOSE OF CONTACT (MARK ONE)

INDIVIDUAL THERAPY
FAMILY THERAPY
GROUP THERAPY
PSYCH TESTING
COMMUNITY DEVELOPMENT
CONSULTATION
COOPERATIVE EFFORT
EDUCATION
GRANTSMANSHIP
PREVENTION
REFERRAL
SURVEYS, RESEARCH
OTHER

13. PRIMARY ASSISTING RESOURCE (MARK ONE)

CONTRACT RESOURCE
HEALTH DEPARTMENT
NATIVE PRACTITIONER
PRIVATE INSURANCE
SOCIAL SECURITY
STATE/COUNTY
STATE INSTITUTION
TRIBAL ORGANIZATION
VETERANS ADMINISTRATION
VOCATIONAL REHABILITATION
VOLUNTARY/PRIVATE
WELFARE DEPARTMENT
IHS
BIA
TITLE 18
TITLE 19
GRANTS
HOUSING
OEO
EDUCATION
EMPLOYMENT
NONE
OTHER

BEST COPY AVAILABLE

1. A way to systematically link these mental health data with any other records system,

2. A method of processing that avoids a record rejection rate exceeding 25 percent overall,

3. Clearly defined procedures for what and when to report,

4. A more accurate and useful method of identifying and encoding presenting problems,

5. Methods of encoding action taken,

6. Procedures for assessing changes in the recipient's status, and

7. Systematic organization of information into a data base.

In short, the present SS and MH reporting system has an inadequate input document, an inappropriate system for processing the data, and no provisions for data base maintenance.

A Framework for Change

In February 1980, a system design and implementation task force, working under the auspices of the Division of Biometry and Epidemiology, NIMH, completed a five-year collaborative effort between federal and state agencies addressing design development of a standardized and integrated Mental Heath Statistical Reporting System. This report, The Design and Content of a National Mental Health Statistics System, Patton et al., 1983, DHHS Pub. NO. (ADM) 83-1095, has served as the model for design guidelines in a proposed IHS mental health information system.

The system proposed by the task force defined three types of data to be routinely collected, along with both uniform data elements (UDE) and minimum data sets (MDS) for each of these three types of data collection:

1. Organizational Data

   Systematic descriptive statements of program features which can be used to make assessments of the various units, program elements, or other sub-divisions that make up a total program. In IHS, the permutations and possible combinations sometimes preclude any serious inter-organizational comparisons and often complicate intra-organizational evaluations.

2. Personnel Data

   Systematic collection of information about staff, their demographics and relationships to the organization, and periodic assessment of the activities they engage in during a sample work week. These data can be used to

address manpower, training, resources distribution, program evaluation, and workload issues and questions.

This set of data can also form the basis for program-oriented position control.

3. Client/Patient Data

In addition to demographics and social data on the client/patient, certain census reporting periods are specified so that more than simple workload information can be derived. The problem in IHS is more complex, until more adequate data-base materials are developed and some form of integrated record system is decided upon.

The minimum data sets, as well as lists of other recommended data items, were developed and field tested for each of these types of data. IHS Mental Health Programs participated in a field test of the uniform data elements and minimum data sets for personnel data carried out by the Western Interstate Commission on Higher Education (WICHE) in 1981.

National Institute of Mental Health definitions and standards were used by the Office of Mental Health Programs in developing descriptive standards for IHS program operations. These were included in the proposed Office of Mental Health Programs policies and procedures manual chapter, the program review document for developing adequate scope of work statements in P.L. 93-638 contracting, and in the review procedures used for program management reviews.

Within this conceptual framework, the Office of Mental Health Programs' strategy for information system development involves two major and two supplementary efforts. One thrust is to field test, evaluate and revise a new input document for possible service-wide use by IHS and tribally contracted Mental Health Program efforts. The second is to finalize the development of two specialized data bases which are being developed from existing but disparate records systems. These two major thrusts, at an appropriate point in the future, would merge in a single sub-system of records which would sit "within" or "between" other appropriate systems, selectively drawing on each for specific information relative to mental health issues, and organizing these data in such a way that a variety of program specific, population specific, provider specific, or problem specific questions could be addressed. The supplementary efforts would address articulation of effort (captured by the new input record) with cost accounting information in a more precise and usable fashion, and refinement of the personnel information capture initiated through the collaborative effort with WICHE.

1. Attneave, C.L., and Beiser, M., Service Networks and Patterns of Utilization, Mental Health Programs, Indian Health Service, 1974.

2. Civil Commitment of American Indians, an ongoing study by Bloom, et al.

3. Drug Use Among Native American Youth, 1975-1981, a study by Oetting, et al.

4. Krush, L.P., and Bjork, J., Mental Health Factors in an Indian Boarding School, Mental Hygiene, Vol. 49, No. 1, January, 1965, pp. 94-103.

5. Goldstein, G.S., The Model Dormitory, Psychiatric Annals 4(9), 1974, pp. 85-92.

Organization and Funding

Background for Discussion V

In the early history of the IHS Mental Health Program, organizational and funding issues seemed much simpler. In a 1974 base line study (1), Attneave and Beiser characterized the atmosphere of the program and the style of the administration as giving approval to creative problem solving and as being related to the Indian communities in a style of mutual respect. The authors identified several models for service delivery and for relating to other mental health resources. They praised the extent of flexibility evidenced in program development, which permitted compatible working relationships with traditional healers, and went on to state:

> In essence the structure of Mental Health Program administration has been more like that of a network of service delivery units, each linked in a variety of ways to one another, than it has been a bureaucratic creation. This style has also fostered the extension of program development to include other agencies, tribal, private, state, and federal. The essential interdependence of peoples has been recognized at not only the clinical level, but also in the integration of services and programs within the local context.

In the final chapter of the overview volume of their report, these authors also recommended preservation of "the essential flexibility, local autonomy, and creative innovation" they observed. This section will address some of the problems that have arisen out of the increased complexity of the overall IHS organization, the increased size of the Mental Health Program and its increased sophistication in programming and treatment.

Role of the Office of Mental Health Programs

The Office of Mental Health Programs has the following functions: (1) plans, develops, and coordinates a comprehensive mental health program for the Indian Health Service in relation to stated goals and objectives and changing Indian needs nationally in 12 major Area and Program Offices serving over 800,000 American Indians and Alaska Natives with 82 Service Units, 48 hospitals, 76 health centers, 14 school health programs, and 82 health stations, plus a considerable number of facilities and programs administer by tribes; (2) provides technical consultation to tribal groups and IHS staff in respect to mental health concerns; (3) represents the IHS in advocating, coordinating and joint planning with state, federal, tribal, professional, private and community organizations in the identification, development and use of alternate resources for mental health services to Indian people; (4) gives strong leadership in raising the quality of mental health care provided the American Indian and Alaska Native population; and (5) is a central source of information and communication on mental health needs and services within the Indian Health Service.

The Indian Health Service is a Bureau of the Health Resources and Services Administration (HRSA). The most recent organizational chart for the Indian Health Service (on the following page) locates the Division of Program Operations (DPO), to which the Office of Mental Health Programs reports. The Division in turn reports to the Deputy Director and the Director.

Since the Office of Mental Health Programs (OMHP) was established in 1967, its role has changed from that of obtaining and managing funds, recruiting staff and providing program supervision to a more purely consulting and coordinating model. In its current role, the Office of Mental Health Programs has responsibility for coordinating a comprehensive mental health program but is without line authority relative to the Area programs for funds, personnel, or program direction. There are inherent problems in exercising program vs. line authority that have affected both the Office of Mental Health Programs and the Area Mental Health Branches. Examples of these problems include diverting of funds by line officials to make up for deficits in other areas or programs, staff selection, setting program standards, and lack of funds to bring Area staff together.

The Role of the Mental Health Branches in Relation to Other Area Components

Originally, Area Branch Chiefs administered and supervised the field program staff and had much the same role at the Area level as the early Headquarters mental health staff. As IHS became increasingly decentralized, some of the Area Branches were reorganized, and in most instances the Branch Chiefs were redesignated "consultants". (Throughout this document, however, they will be referred to simply as Branch Chiefs.) Most field operational authority was delegated to the Service Unit Director, who thus had both administrative and program supervisory authority. The Area Branch Chiefs were frequently seen as having no authority over the programs for which they were the Area's acknowledged experts and for which they were de facto held responsible. Predictably, there were problems with this, because of the conflict between program and administrative needs. In addition, what was a technical issue became an emotional issue and capacity for dealing with this problem was lessened.

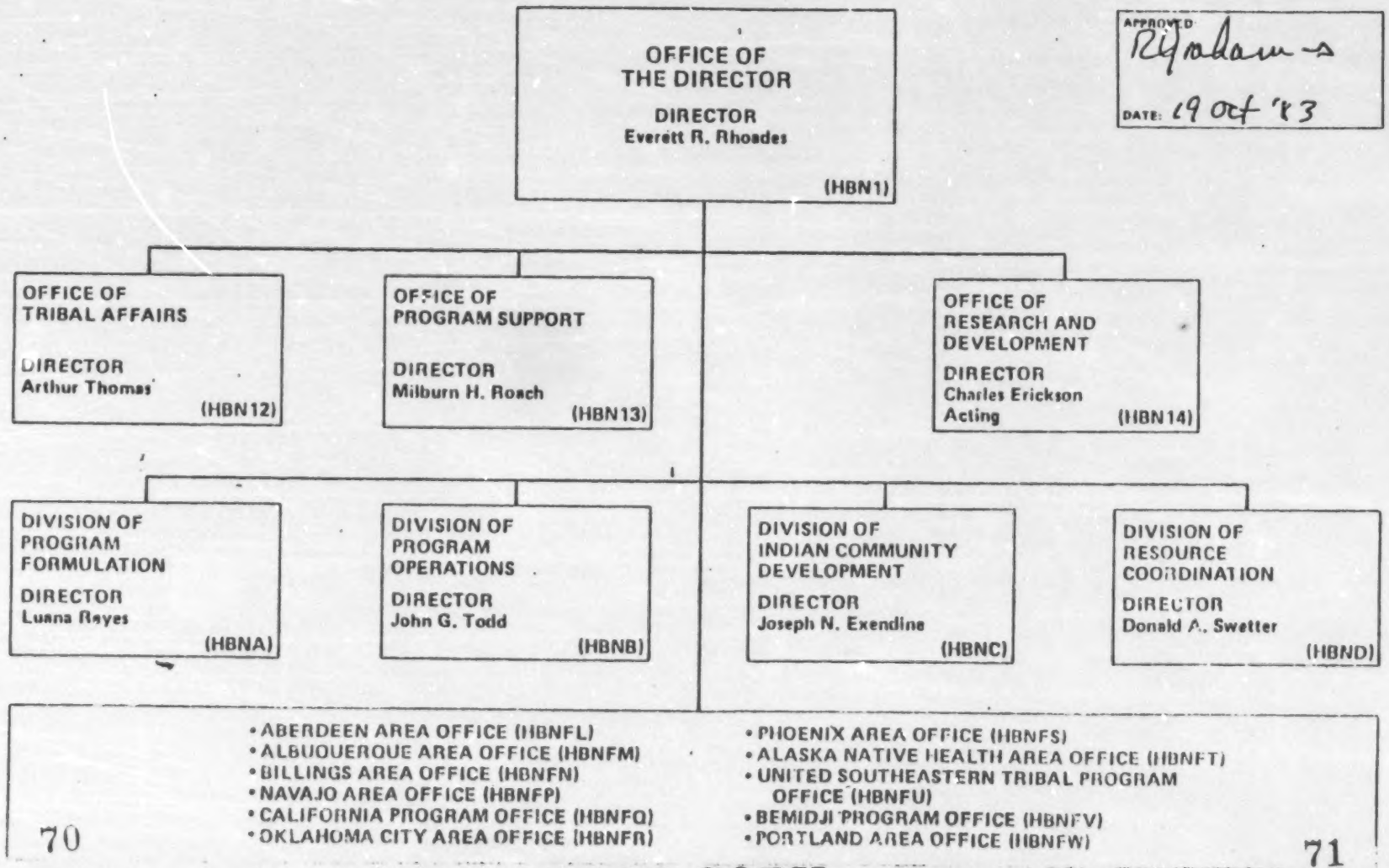
Another problem in many Areas has been that of a literal application of the definition of "consultant", i.e., one who is a professional and technical expert, but who has no authority or decision making responsibility within the system. In reality the Area Branch Chiefs serve in a variety of roles: (1) consultant, (2) liaison officer, (3) educator, (4) supervisor, and (5) collaborator.

Relationships at the Area Level Among Mental Health Program, Social Work Services, and Alcohol Program Staffs.

The Indian Health Service, since its inception, has been increasingly decentralizing its operations. As this process has moved through the organization it has resulted in shifts in authority and responsibility. Each Area Director has structured his or her organization relatively autonomously. Varying Area program emphases have placed

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Indian Health Service



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Mental Health Programs within differing components of the organization. For example, Mental Health Programs are in Program Services, Preventive Health, Community Health Services, and Quality Assurance offices, depending on the Area. There are combined Mental Health/Social Service programs in some Areas, and combined Mental Health/Social Service/Alcohol programs in others. Still others are free standing within the Area. Mental Health and Social Work Service programs usually are in the same subdivision, however, while Alcohol Program coordinators are at times in community development or tribal development offices.

Relationship of Area Branch Chiefs to the Service Units

Area Branch Chiefs have several roles in relation to the Service Unit Directors, Service Unit staff, and tribal programs. Generally, the Branch Chiefs serve as program or administrative consultants to the Service Unit Directors and as case and program consultants to Service Unit staff. Ideally, Branch Chiefs set mental health program standards and monitor and evaluate these programs. They work collaboratively with the Service Unit Director and program staff in implementing recommendations. Ideally, due to the small number of technical staff at the Service Unit level, the Branch Chief and Service Unit Director are jointly responsible for overseeing the quality of the program and for evaluating staff performance. Also, ideally, there is a collaborative relationship between the Service Unit Director and the Branch Chief concerning major program changes, program priorities and required qualifications for positions.

The staffing and organizational location of programs at the Service Units is also variable. In relationship to the mental health staff, we find:

1. Facilities with no staff;

2. Separate mental health programs with as few as one staff to as many as twenty or more, such as inpatient programs;

3. Combined social service and mental health programs under various kinds of supervision;

4. Alcohol programs, either IHS or tribally contracted, in which frequently the Project Officer is a Service Unit mental health staff person. This staff person is often relied upon for technical assistance, training, and case referral and serves also as Service Unit alcohol representative;

5. Mental health staff functioning as Field Health Director or Acting Service Unit Director for long periods; and

6. Service Unit and tribal joint programs with administrative problems due to the need to function under a wide variety of funding and legislative authorities, such as earmarked IHS mental health, IHS hospitals and clinics, IHS contract, Community Mental Health Centers, private

insurance, Medicare/Medicaid, and state and county dollars. (Dealing with the varying standards, reporting requests and supervisory practices associated with these activities consumes considerable staff time.)

Budgeting, Allocating, and Accounting for Mental Health Funds

Growth of the IHS, which has brought increased levels of complexity, has resulted in a shift to more of a business model of administration rather than a service model. In the effort to be financially accountable, the purpose of providing services has sometimes been subordinated. However, the gap between the level of services required and the ability of the IHS, financially, to deliver them is widening quite independently of anyone's wish.

Problems in Projecting Needs for Funds and Staff

The Resource Requirements Methodology (RRM) was originally intended to be used to determine funds and staff; however, the RRM for mental health is in need of updating.

Tribal specific health plans mandated by P.L. 94-437 are used to project need. However, tribes have the option whether or not to request consultation from the Mental Health Branch. Similarly, P.L. 93-638, which provides for tribal contracting of mental health services, may or may not involve the Mental Health Branch in the development of the contract or in the provision of services. The program may be part of an "umbrella" contract or grant and, depending on the contracting officer, Project Officer, tribal development staff, and policies and procedures, may or may not clearly specify what mental health services are funded or envisioned by the tribe. Equity health care funding procedures are subject to the same problems.

Contracts are developed with professionals, professional schools, etc. to provide services when it is not feasible for IHS to hire certain specialty staff. Contract health services may be utilized for both inpatient and outpatient mental health care. However, priorities and authorization decisions are typically delegated to the Service Unit and are usually reserved for more purely medical rather than psychiatric services.

Needs for Travel and Training Funds

During recent fiscal years the IHS has had to deal with a serious budget shortfall. A result of this has been cutbacks in travel and training. This is a program as well as financial issue. For a program as dependant on travel as is the Mental Health Program, restrictions on travel translate into restrictions on services.

From time to time, funding for training is restricted or is not available and other training resources are non-existent. Provision for mental health staff training should be considered as mandatory as training for such groups as physicians. The Mental Health Program historically has been concerned with Indian people functioning in treatment roles in the program. Early on, the development of

paraprofessional positions (mental health technicians) flourished. Many of the technicians have now attained professional status through upward mobility, long term training and/or P.L. 94-437 education funds. We continue to have technicians providing care in remote locations, providing important services benefits, which further points to the need for continuing training funds.

Organizational Implications of Issues Relating to Involuntary Commitment

In the organization and funding of IHS mental health services, involuntary commitment needs have posed a variety of philosophical, ethical, legal, and professional issues to the Indian Health Service. Many of the philosophical and ethical issues have been translated into legal problems.

The main focus of major commitment cases is jurisdiction of various governmental bodies, that is, the rights of tribal governments vis-a-vis the rights of states. The complex legal issues involved in civil commitment cases are summarized in two articles, one by Eric Henderson and one by Bloom, Manson and Neligh (2,3). Bloom and Manson are also involved in a current research project examining factors affecting civil commitment processes for mentally ill American Indians (4).

Civil commitment cases affect the Mental Health Program in multiple ways. First, there is a need to assure access to appropriate treatment for Indians for whom involuntary commitment is indicated. Involuntary commitment has raised issues involved in accessing appropriate resources and associated costs. IHS does not currently have a program for the chronically mentally ill, i.e., group homes, day treatment programs, social and behavioral reinforcement programs, drug monitoring, and support networks. If such services were in place within the IHS system, the need for extended involuntary commitment admissions might be lessened and the overall costs to the IHS might be lowered.

Involuntary commitment also raises important issues relating to competent clinical supervision. The IHS lacks a chain of clinical supervision that is legally defensible in a court of law. This fact becomes increasingly significant as mental health field staff make decisions that may be challenged in legal actions. For example, there are no Areas in which the Chief Medical Officer is a psychiatrist. The judgement of physicians of other specialties and of lay administrators is less likely to be accepted in legal proceedings.

In conclusion, if there is one organizational issue which stands out above the rest, it is the need to clarify the roles and interrelationships of all mental health staff and the relationships of the Mental Health Program to the other components of the IHS.

1. Attneave, C.L., and Beiser, M., Service Networks and Patterns of Utilization, Mental Health Programs, Indian Health Service, 1974.

2. Henderson, Eric, Involuntary Civil Commitment of American Indians Residing in Indian Country, Arizona Law Review 24:101-119:1982.

3. Bloom, Joseph D., Manson, Spero M., and Neligh, Gordon, Civil Commitment of American Indians, Bulletin of the American Academy of Psychiatry and the Law 8, 1980.

4. Bloom, Jeseph D. and Manson, Spero M., Civil Commitment of American Indians, an ongoing research project.

Contracting Under P.L. 93-638

Background for Discussion VI

Since 1955, the Indian Health Service has experienced numerous changes, resulting in the comprehensive health delivery system of 1983, which have taken it substantially beyond its original public health model. As the objectives of the IHS have changed to include the delivery of health care for the entire spectrum of physical and mental illness, resource demands have increased correspondingly. Likewise, as the program has expanded, there have been special efforts to clarify the unique relationship that exists between tribes and the federal government, in order to assure that the health care needs of Indian people are effectively addressed.

Public Law 93-638, the Indian Self-Determination and Education Act, frequently referred to as 93-638 or simply as 638, passed by the Congress in 1975, provides the authorization and establishes the procedures whereby tribal organizations which are interested can assume responsibility for the operation of health programs provided by the Indian Health Service. The rules and regulations for IHS governing implementation of this act are spelled out in 42 CFR 36 dealing with P.L. 93-638 contracting. Two mechanisms are available, grants and contracts. The former addresses development and capacity building, while the latter is essentially for programs currently being conducted and administered by the IHS. The major difference is that all contracted programs are part of the IHS continuous operations, whereas grant-funded projects have no requirement that the IHS continue the project beyond the grant period. Funding for contracting is drawn directly from the IHS funding base, while grant funding is more problematic and contingent on specific appropriations.

The Federal Policy Shift in 1970

P.L. 93-638 was the culmination of a decade of emphasis begun during the Nixon Administration to increase the voice of Indian people in their own affairs. President Nixon's message to Congress on Indian policy in 1970 signaled a major initiative to bring about basic and long-lasting positive changes in the administration of the federal programs addressing Indian concerns. The following quotation expresses this national policy under President Nixon, that preceded P.L. 93-638 and also P.L. 94-437, the Indian Health Care Improvement Act.

> For years we have talked about encourging Indians to exercise greater self-determination, but our progress has never been commensurate with our promises. Part of the reason for this situation has been the threat of termination. But another reason is the fact that when a decision is made as to whether a Federal program will be turned over to Indian administration, it is the Federal authorities and not the Indian people who finally make that decision.
>
> This situation should be reversed. In my judgment, it should

be up to the Indian tribe to determine whether it is willing and able to assume administrative responsibility for a service program which is presently administered by a Federal agency. To this end, I am proposing legislation which would empower a tribe or a group of tribes or any other Indian community to take over the control or operation of Federally-funded and administered programs in the Department of the Interior and the Department of Health, Education and Welfare whenever the tribal council or comparable community governing group voted to do so.

Under this legislation, it would not be necessary for the Federal agency administering the program to approve the transfer of responsibility. It is my hope and expectation that most such transfers of power would still take place consensually as a result of negotiations between the local community and the Federal Government. But in those cases in which an impasse arises between the two parties, the final determination should rest with the Indian community.

Specifically, mental health, alcoholism and chronic otitis media were singled out, again in the Nixon policy statement:

This administration is determined that the health status of the first Americans will be improved. In order to initiate expanded efforts in this area, I will request the allocation of an additional $10 million for Indian health programs for the current fiscal year. This strengthened Federal effort will enable us to address ourselves more effectively to those health problems which are particularly important to the Indian community. We understand, for example, that areas of greatest concern to Indians include the prevention and control of alcoholism, the promotion of mental health, and the control of middle-ear disease.

Indian Health Service Policies and Responsibilities Concerning P.L. 93-638

In addition to the general regulations governing contracting under the provisions of P.L. 93-638 included in 42 CFR Part 36, a number of memos and circulars clarifying responsibilities and procedures to be used have been issued. In October 1983, an evaluation of the current procedures was begun by the National Indian Health Board under contract to the Health Resources and Services Administration.

Probably the most important IHS responsibilities associated with this Law are:

1. That IHS assure that there is no significant reduction in services as a result of contracting;

2. That, while IHS cannot solicit or encourage tribal contracting, every effort be made to assist and help an interested tribe to assume these responsibilities; and

3. That contingency plans for retrocession (voluntary relinquishment of a function being operated by a tribal organization back to the control of the IHS) and reassumption (involuntary termination of IHS support and a return of the program to IHS control and operations) be in place to assure that adequate levels of service are maintained. This would assure the continued provision of services by the IHS, in the event that either of these alternatives is necessary.

Health Program Standards

The IHS has a responsibility to spell out health program and professional standards governing its own operations, which can be used by a prospective contractor to develop an appropriate proposal.

The Indian Health Manual, Part 3, Professional Services, establishes "minimum health program and professional standards." These standards meet the requirements of the regulations and are applicable throughout the IHS.

The Manual, however, does not provide standards for every health service activity of the IHS. Where the Manual does not identify standards for an activity, the standards established by the appropriate national standard-setting or accrediting body are applicable to that activity. For example, there are no standards in the Manual for clinical services. Thus, current Joint Commission on Accreditation of Hospitals, Health Care Financing Administration, and other recognized appropriate national and IHS standards apply to the operation of clinical facilities operated directly by, or under contract with, the IHS.

Since mental health services are hard to quantify, and there are considerable differences of opinion as to what types of services may have impact, a sound and consistent implementation of P.L. 93-638 has been problematic. The problems encountered in the Mental Health Programs are summarized more fully below.

Administrative and Organizational Issues

Not all Areas are affected by 638 contracting to the same degree. The table on the following page summarizes amounts of tribally contracted programs for FY 1981-1983. However, contract requests for existing programs seem likely to increase in the coming years. And, as these new requests for P.L. 93-638 mental health contracts are received, it is increasingly important that there be a mechanism in place to assure that funds will be properly used.

There is no discussion in the IHS Manual detailing roles and responsibilities of the Office of Mental Heath Programs with respect to P.L. 93-638. Thus, the roles and responsibilities of the Office of Mental Health Programs are currently unclear with respect to P.L. 93-638 contract projects. When decisions need to be made on matters pertaining to P.L. 93-638 contracts, the Headquarters program office role is unclear, and guidance is often not obtained on decisions that have an impact on program activities. For example, the Office of Mental Health

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Table 1

EXPENDITURES* FOR MENTAL HEALTH PROGRAM ACTIVITIES, FY 1981-83

	FY 1981			FY 1982			FY 1983		
	IHS	Tribal	Total	IHS	Tribal	Total	IHS	Tribal	Total
Aberdeen	885,500	226,600	1,112,100	781,700	241,300	1,023,000			
Alaska	723,200	398,100	1,121,300	792,600	336,100	1,128,700			
Albuquerque	566,100	272,200	838,300	758,300	73,000	831,300			
Bemidji	154,400	40,700	195,100	187,200	28,100	215,300			
Billings	638,000	17,700	655,700	628,500	42,600	671,100			
California	---	205,900	205,900	---	136,900	136,900			
Navajo	1,180,400	---	1,180,400	1,332,300	---	1,332,300			
Oklahoma	1,027,200	---	1,027,200	831,300	---	831,300			
Phoenix	663,300	35,600	698,900	685,600	134,500	820,100			
Portland	609,400	608,900	1,218,300	687,100	231,600	918,700			
Tucson	35,000	192,200	227,200	69,200	131,500	200,700			
U.S.E.Tribes	88,600	238,400	327,000	79,400	262,600	342,000			
Hdqtrs-West	493,700	---	493,700	583,200	---	583,200			
T O T A L	7,064,800	2,236,300	9,301,100	7,416,400	1,618,200	9,034,600			

*These figures were drawn from Cost Center reports SHR-285,285A, 388A and 388B for Mental Health Activities (all 61 Cost Centers). They include the unexpended balance of committed funds where it appears that the contract year is not coterminous with the Fiscal Year used by IHS. Budget activities shown include Hospitals & Clinics, Mental Health, Contract Health Care and Equity Health Care.

Programs does not participate in revisions of 638 regulations and circulars, nor are the views of Area staff solicited. Conversely, for Areas involved heavily in contracting, there are Area circulars that spell out respective authorities and responsibilities for various program and administrative officials for each phase of the contracting process.

Program staff are infrequently involved early in the contracting process. Typically, an Area Branch Chief's first involvement in the process is when he or she is informed that a scope of work statement is needed to cover certain proposed operations at a specific location. The entire process is generally thought of as an administrative/management issue, primarily involving the tribal affairs, finance, and contracting offices and only peripherally involving program services. Moreover, Branch Chiefs may be made Project Officers, or Technical Project Officers, roles which put them in the awkward situation of wearing both monitoring and program consultative "hats".

The issue of adequate program staff to carry out the complex requirements of 638 monitoring, as well as case and program supervision and technical asistance, is an important one that has not been fully addressed.

In addition, the lack of separate funding for tribal indirect costs has become a significant management issue. To some, this means that certain 638 contracts for mental health, which the tribe perceives as including administrative costs, may provide fewer services than could be provided directly through the IHS system. In addition, it should be noted that there is no uniformity in indirect cost rates from tribe to tribe. (The rates range from less than 10 percent to almost 50 percent.)

Finally, IHS lacks a management information system to monitor these contracts adequately, so that questions of cost per unit of service or quality of service cannot be answered systematically. Individual Areas may have local systems for contract report requirements and contract monitoring, but data from different Areas are not always comparable.

Programmatic Issues

The issue of clear program standards is serious. No final policy and procedures manual issuance is in place, and only a draft set of guidelines incorporating standard definitions and JCAH principles is available. Consequently, it is difficult to make definitive statements of minimal program operations.

Setting performance standards and maintaining personnel qualifications are recurring problems, which are directly related to the issue of program standards. Moreover, the lack of procedures to deal with noncompliance in these areas frustrates IHS staff, confuses service recipients, and contributes to the awkward situation of the dual role of program staff referred to above.

The impression held by many clinical staff is that the 638 contracts are expensive and do not seem cost-effective. Community groups, on the other hand, are making increasing requests for additional 638 contract projects, for both new projects and "take-over" requests. IHS must assure the Congress, moreover, that adequate technical assistance is being provided to Indian tribes to accomplish the purposes established in P.L. 93-638, even though resources are limited.

In reviewing the problems summarized above, it would appear that much improvement can be accomplished, if they are approached in a systematic fashion and if an adequate funding base is assured. Improved planning, based on explicit, sound standards, and dedication on the part of both Indian people and the Indian Health Service to the spirit and intent behind the Law would surely help in improving service delivery.

Rethinking of the Mission and Future Direction of the IHS Mental Health Program

Background for Discussion VII

This concluding section must be considered, at most, a beginning, in preparation for exploring and clarifying a number of outstanding issues pertaining both to the Mental Health Program and its relationship with the rest of the IHS. The hope and assumption is that this Program Review will facilitate this process, document it, and raise it to a higher level. We emphasize that exploration and clarification of issues is an ongoing process and that this section is only a beginning toward that end.

The Mental Health Program within IHS encompasses services for inpatients and outpatients, home visits, and activities related to the community. All these efforts seek to provide a comprehensive mental health care system based upon the public health model.

Staffing Concerns

These diverse activities are best carried out by a multidisciplinary team. The team should include psychiatry, clinical psychology, psychiatric social work, psychiatric nursing, public health and hospital nursing, alcoholism workers and others appropriate to the setting, working closely with paraprofessionals who are sensitive to sociocultural factors in their communities that play a role in the individual's mental and emotional state. Paraprofessionals are involved in evaluation and counseling in hospital outpatient and field settings. They often act independently in providing care, with recourse to professional consultation as necessary.

It is important that the complexity of evaluation and case management of our clients and patients be appreciated. Mental health staff are confronted with a broad gamut of challenges, ranging from the problems and crises of everyday life to the full spectrum of serious mental illness, violence to self or others, alcoholism, drug abuse, etc. Skillful diagnostic ability and knowledge of many modalities of treatment are essential. The stresses of everyday living in the Indian population are aggravated by economic hardship, higher-than-average morbidity and mortality, unemployment, sub-marginal educational level, sub-standard housing, problems of distance and transportation, and cultural factors, all of which may contribute to family disorganization and stress. These factors heighten depression, anxiety, and other emotional symptoms with consequent added pressure on family members, fellow workers and the community.

Many of our field locations are seriously understaffed. We estimate that twice to three times the mental health staff is necessary to serve the population.

Burnout among health staff is often encountered, at least in part as a result of the seemingly unending, difficult decisions they must make as well as the number of people they must serve due to staff shortage.

Since staff training is so important in maintenance of quality treatment skills, employee morale, and prevention of burnout, we should use every means of training available to us in maintaining our efforts.

One very real concern is the problem of keeping our excellent staff, if severe budget restraints or organizational problems continue unabated. Those of our staff who are expressing alarm over the level of services and quality of patient care being delivered are not merely a few disaffected malcontents, but are professionals who are concerned about doing their job ethically. The point is that the IHS may be dangerously close to providing only this reduced level of care, in which case we may have difficulty in attracting and retaining good staff. The high physician turnover throughout the IHS is thought by some to be at least in part attributable to this factor.

Priorities are often set by external circumstances. The realities of staffing and financing have precluded the creation of optimal teams and services in most Service Units. It is evident that the range of services offered by mental health staff is limited and depends upon the expertise and skills of whatever staff can be recruited. In these situations, it is important for Area staff, Service Unit Directors, and Clinical Directors to negotiate the most effective staffing given budgetary constraints, and for mental health staff to modify their expectations as to what can be achieved by each person. Clearly, one mental health technician or psychiatric social worker can only do so much. Unrealistic expectations among Service Unit staff cause extreme stress, that then may require intervention from Area staff.

Mission and Program Emphases

One frequently hears comments to the effect that what the Mental Health Program does is not generally understood by others. We believe it is essential that the roles of mental health personnel and services provided by them be clarified.

Certain programs and services have been in place long enough that we should be able to demonstrate their value. Specifically, these include the model dormitories and the Indian Children's Program. Our observation is that these programs have effectively served as early intervention programs of the type strongly recommended by Berlin and others (1).

In another prevention-related activity, efforts have been initiated jointly with the Centers for Disease Control to identify specific risk elements. Regional differences are noted as well as recognition of a key age group, men aged 15-24 years, in which there is a high death rate from violent accidents and firearms and in which alcohol use or abuse is involved. Further identification of risk groups and risk elements is indicated as well as development of specific prevention strategies for each risk group.

The IHS is currently developing an alcoholism prevention plan and model communitiy alcoholism prevention program to be implemented IHS-wide. Since many violent deaths--fatal accidents, homicides and suicides--are alcohol-related, this effort should ultimately reduce the incidence of

such deaths. Also, IHS is currently engaged in efforts addressing the fetal alcohol syndrome. (This program is described in Discussion III, Services for Children and Adolescents.)

For future effectiveness, the IHS Mental Health Programs should explore the following challenges in Indian Mental Health:

1. Programs for the care of the chronically mentally ill,
2. Programs to meet the challenge of drug abuse in the Indian population,
3. Development of psychiatric units in Indian Health Service general hospitals, and
4. The need for a residential psychiatric treatment facility for Indian children.

In order to implement further development of the Mental Health Programs, either as they stand or in new directions suggested during these discussions, the following issues should be addressed:

1. Reassessment of the Mental Health Program's mission, goals and priorities,
2. Development of a uniform recording and data system,
3. Review of standards of care,
4. Completion of an Office of Mental Health Programs policy manual,
5. Regular periodic dialogue and review between the Office of Mental Health Programs and Area Mental Health Programs, individually and as a group,
6. Definition of minimum standards and training programs for mental health staff, professional and paraprofessional, and
7. Establishment of uniform guidelines for the increasing numbers of P.L. 93-638 contracts.

We trust that in the examination of these organizational and treatment issues, definitive recommendations will result in a strengthening of the Mental Health Program.

1. Berlin, Irving N., Prevention of Emotional Problems Among Native American Children: Overview of Developmental Issues, Journal of Preventive Psychiatry 1 (3), 1982.